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OFFICIAL

Detention Health: Mental Health

Procedural Instruction

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1. Purpose

This procedural instruction (PI) provides instructions on the mental health policy and procedures for managing mental health issues of the Department of Home Affairs (the Department), including the Australian Border Force (ABF), in onshore immigration detention. Content in this PI includes guidance on understanding and managing mental health conditions and minimising associated harms. Contracted service providers (and their subcontractors) are required to act in accordance with this PI and any applicable law, and any policies, procedures, values, standards or principles as specified by the Department.

This Procedural Instruction (PI) is intended for use by the Detention Health Services Provider (DHSP) and Facilities and Detainee Services Provider (FDSP) staff, all officers within the Department of Home Affairs (the Department) including the Australian Border Force (ABF) and other relevant contracted service providers who provide health services to detainees in immigration detention in accordance with legal obligations.

In this PI, all further references to the DHSP includes any relevant contracted service providers who provide health services to detainees in immigration detention. Furthermore, all further references to the Department includes all officers with the Department including the ABF.

For further guidance or clarification regarding the content of this policy please contact the Detention Health Policy and Program Support Section at health@homeaffairs.gov.au

Please see the Detention Health: Suicide Prevention Framework – PS (HR-4983) for further information.

1.1 Provision of services to detainees pursuant to Residence Determination

Detainees pursuant to Residence Determination (RD) live in the community and are managed via a different mechanism, being the Status Resolution Support Services (SRSS) Program. SRSS Providers support detainees in RD in managing their health needs in collaboration with the DHSP in line with the SRSS Operational Procedures Manual (OPM) V8 (ADD2019/851260).

These detainees have their health care needs provided for by the DHSP, through its network of general and specialist practitioners and pharmacy providers. The DHSP is responsible for coordinating health care for detainees pursuant to RD arrangements, including any necessary referrals for specialist support services.

SRSS Provider Case Workers are required to maintain regular contact with all detainees pursuant to RD at a minimum of once per month (face to face contact in-person) at the designated RD property. This may be more frequently depending on the individual care needs of the detainee.

For detainees pursuant to RD arrangements, the SRSS Provider must work closely with the Department to ensure that appropriate follow-up support is available to minors and their families. Follow-up support includes referrals to appropriate mental health and associated services and supports. For further guidance on the SRSS program and the roles of SRSS providers please refer to the SRSS OPM V8 (ADD2019/851260) or contact SRSS Contracts via email at srss.contracts@homeaffairs.gov.au. For information and guidance regarding detainee placement in RD, refer to the s197AB Ministerial Intervention Team via email at ministerial.intervention.195A_197AB@homeaffairs.gov.au.

2. Scope

2.1 In Scope

This PI applies to detainees in immigration detention:

- immigration detention centres (IDCs)
- alternative places of detention (APOD)
    - facility APOD - immigration transit accommodation (ITA); and
    - non-facility APOD – places in the broader community which have been designated as places of immigration detention.

This PI also applies to those detainees who are detained, covered by RD arrangements and supported through SRSS:

- unaccompanied minors (UAMs) who reside in the community covered by a RD
- detainees who are single adults and families who reside in the community covered by a RD.

3. Procedural Instruction

3.1 What is mental illness?

Mental illness is health conditions which involve disturbances in emotion, thinking or behaviour (or a combination of these). Mental illness is associated with distress and/or impaired functioning in social, occupational or recreational activities. Mental illness is treatable[1]. The vast majority of people with mental illness continue to function in their daily lives.

Application of the settings in this PI, including screening, identification, treatment and management, should be clearly understood as variable, subject to the particular clinical requirements of a detainee (with clinical instruction).

The determinants and symptoms of mental illness can be influenced by a specific aspect or combination of individual attributes, social circumstances and living environment. Factors such as stress, bereavement, physical and sexual abuse, unemployment, social isolation, illness and contact with the justice system, may contribute to the development of mental illness.[2]

Significant mental illness and health disorders are common within the immigration detention network, and can include:

- anxiety disorders
- post-traumatic stress disorder (PTSD)
- mood disorders including depression and bipolar affective disorder
- personality disorders
- drug and alcohol use disorders
- psychotic disorders

[1] *What is Mental Illness*, American Psychiatric Association, Washington DC, USA, viewed 29 June 2023, www.psychiatry.org
[2] *World Mental Health Report June 2022*, World Health Organization, Geneva, Switzerland, viewed 29 June 2023, www.who.int

- psychosomatic disorders (including disorders in which the physical symptoms are caused or exacerbated by psychological factors, such as migraine headache, lower back pain, or irritable bowel syndrome).

For more information on trauma related responses, refer to section 3.3 Mental Health Trauma Services in an IDF of this PI.

Symptoms of anxiety and depression can include the following:

- sweating or trembling
- loss of interest in life
- heart-racing
- light-headedness or nausea
- sleeping too little or too much
- irritability
- excessive worrying
- significant weight changes
- feeling worthless or guilty.

Note: this list is not exhaustive and these factors do not necessarily mean that the person has a mental illness[3].

Symptoms of PTSD can include but are not limited to[4]:

- intrusive memories of the trauma while awake and nightmares during sleep
- emotional distress in response to reminders of the trauma
- active avoidance of talking about the trauma or behavioural avoidance of reminders
- pervasive negative thoughts and mood disorder (anger, guilt, lowered mood, anxiety)
- hypervigilance to future threat
- heightened arousal and reactivity including sleep and concentration problems, anger, startle reactions.

Note: For more information on trauma related responses, refer to section 3.3 Mental Health Trauma Services in an IDF of this PI.

3.1.1 Use of interpreters

In the provision of mental health services (including screening, assessment and related interviews), all contracted service provider staff and departmental officers should ensure that an interpreter is arranged for any detainee who requires an interpreter (whether due to inability to communicate in English, lack of fluency, or other difficulty in effectively communicating) as far as reasonably practicable. Any interpretation services must be culturally and linguistically suitable for the individual detainee.

The use of interpreters is essential to providing quality care for those who come from culturally and linguistically diverse backgrounds and who are not proficient in the English language. Screening for mental health will also enable the identification of any mental health concerns that negatively impact a detainee's

[3] *Signs and symptoms of anxiety*, Black Dog Institute, Randwick NSW, viewed 29 June 2023, www.blackdoginstitute.org.au
[4] *Signs and symptoms of post-traumatic stress disorder*, Black Dog Institute, Randwick NSW, viewed 3 July 2023, www.blackdoginstitute.org.au

ability to communicate during their time in detention. The DHSP arrangements must ensure that interpreter services are accessible during all clinical consultations and that the clinician is provided education or is experienced in the use of interpreters, as far as reasonably practical.

The FDSP must have arrangements in place to ensure that interpreter services are accessible for all formal communication, such as advising of changes to IDF routines or when a detainee under stress temporarily loses their capacity to communicate fluently in English.

For more information on the use of interpreting and translating services when communicating with detainees in IDFs who are not proficient in English, please refer to Detention Services Manual (DSM) - Communication and engagement – Interpreting and translating services – PI (DM-600).

3.1.2 Record keeping

It is imperative to maintain detailed and contemporaneous records in relation to all matters relating to the mental health treatment and management of detainees. All contracted service providers and departmental staff must maintain good administrative record keeping practices, in line with contractual requirements, and relevant Commonwealth legislation and policies – including the *Privacy Act 1988* and the *Archives Act 1983.*

For more information on record keeping practices, refer to Detention Health: Privacy, Consent and Medical Records – PI (DM-5925).

3.1.3 Centralised Individual Management Plan

A detainee Centralised Individual Management Plan (CIMP) should provide a holistic understanding of the detainee's health, behavioural and welfare needs using a 'joined-up care' and evidenced based approach. In the absence of a live, universally accessible centralised system that provides access to, and enables updating by all stakeholders, the FDSP is to establish and maintain the CIMP by including all relevant information which would contribute to the comprehensive health and wellbeing of the detainee. The FDSP is to request information from relevant stakeholders, including but not limited to the DHSP, ABF Health Welfare Officers (HWO)/relevant ABF Officers and the Department's Status Resolution Officers (SRO).

The CIMP must include a detainee specific care goal section, which clearly describes any requirement for carer services, the nature and target of each goal, the stakeholder/s responsible to action the goal and review timeframes. The CIMP must be established by the FDSP within 21 calendar days from the detainee's arrival into immigration detention and the plan entered into the Department's Compliance, Case Management and Detention (CCMD) portal.

Regular CIMP reviews are to be undertaken by the FDSP within the framework of the mental health assessment process. This includes scheduled and triggered re-screening by the DHSP at six months, 12 months, 18 months, and then at three monthly intervals afterwards for detainees in an IDF. These are the minimum review timeframes. The option of scheduling any other mental health reviews or re-screening are to be made available where clinically required and whenever there are changes in the detainee's circumstances that may impact their health, welfare or behaviour management.

Other health care or behavioural related reviews may also trigger the need for a review of the CIMP by the FDSP, particularly for detainees in detention for less than six months. The DHSP is to advise the FDSP when scheduled and triggered Mental Health re-screenings or other significant health care reviews for detainees are to occur. The FDSP must provide the CIMPs to the DHSP for the re-screenings or health care reviews.

The CIMPs may also be reviewed as required by relevant stakeholders such as the FDSP or the DHSP. Further input may be sought from other departmental or ABF stakeholders at either or several of the following forums:

- Supportive Monitoring Engagement (SME) meeting

- the Individual Management and Placement Review Committee (IMPRC)
- the Clinical Case Review Committee (CCRC) meeting.

Any review discussion must be documented and recorded by the relevant secretariat and the DHSP to verify any clinical input provided via the meeting minutes. The FDSP must enter the updated CIMP into the Department's CCMD portal. If applicable, any relevant changes should also be updated into the Behaviour Management care Plan (BMP). For further information regarding the meeting forums, please refer to section 3.5 PSP related meetings of this PI.

Health information is sensitive and must be managed in accordance with the Australian Privacy Principles contained in the *Privacy Act 1988*. Informed consent must be obtained prior to any clinical procedures being conducted. For guidance on privacy and consent requirements, refer to the Detention Health: Privacy, Consent and Medical Records − PI (DM-5925).

For more information on the mental health re-screening and assessment process, refer to section 3.2.1 mental health re-screening and assessment process of this PI.

The DHSP is not expected to share detailed detainee medical information for the purposes of updating the CIMP to the FDSP. However, any information that could impact on the safety, wellbeing and management of the detainee or others within the detention environment is to be shared with the FDSP.

3.2 Mental health screening and assessment in an IDF

The mental health screening and assessment processes described in this PI may be varied to maintain the detainee's safety and health, as required by the particular clinical presentation.

The purpose of mental health screening and assessment is to record a baseline mental health assessment for each detainee, identify detainees with mental health concerns and provide a basis for the development of individual mental health treatment plans.

Mental health screening and assessment is comprised of the following processes:

- the preliminary mental health screening as part of the health induction general health assessment, undertaken within 72 hours of entry into an IDF
- a comprehensive mental health assessment, undertaken within 10-30 days after first entry into an IDF
- any scheduled and triggered mental health re-screenings at six months, 12 months, 18 months, and then at three monthly intervals afterwards for detainees in an IDF
- any specialist clinical assessment, as required.

The DHSP mental health clinician (such as a mental health nurse) must undertake mental health screening for every detainee as part of the Health Induction Assessment (HIA) within 72 hours of their entry into an IDF. The screening should establish the level and type of risks involved in the individual's detention and the level of urgency for a more thorough assessment to be undertaken. This assessment should establish whether the detainee has any mental health issues by undertaking a preliminary mental health screening, as part of the health induction general health assessment by undertaking the Mental State Examination (MSE) (which includes aspects of cognitive impairment screening). While detainees are encouraged to undertake the HIA, they cannot be compelled to do so, and have the right to refuse. If a detainee refuses any part of the HIA, the DHSP is to discuss the purpose of the HIA and continue to offer further opportunities to complete a health assessment to the detainee.

For more information regarding HIAs, refer to Detention Health: Health Screening and Management – PI (DM-6138).

The detainees must then be offered a comprehensive assessment which considers mental health issues in greater detail. Such an assessment is undertaken within 10-30 days of arrival. However, where mental health illness is suspected, or there are concerns regarding possible or actual self-harm, the person must be referred for further assessment by a mental health professional, such as a psychologist or psychiatrist.

The DHSP mental health clinician must take the following factors into consideration when conducting any mental health assessment:

- any current mental health concerns
- past mental health history
- risk of self-harm
- the need for and facilitation of urgent external medical care
- use of psychotropic medications (current and past)
- family mental health history
- any relevant developmental history including quality of attachments, educational, conduct and behavioural problems
- history of torture or trauma
- drug and/or alcohol use (current and past)
- cognitive impairment
- age
- time in detention and/or incarceration
- criminal charges, and/or
- domestic violence history.

Throughout the mental health screening and assessment, the DHSP is to observe the detainees' mental state and ensure that findings are documented accordingly. It is critical to identify any high-risk behaviours, such as thoughts and intentions of self-harm or suicide, as early as possible.

The DHSP should develop a national framework (the framework) addressing suicide risks and assessment. The framework should be developed based on the core key principles of the *NSW Suicide Risk Assessment and Management Protocol*[5]. The framework should include post evaluation criteria and ongoing auditing to ensure the framework is being used and is having a positive impact on improved mental health and wellbeing for detainees. DHSP clinicians are to use the framework throughout the detention network.

Any detainee identified by the DHSP as having thoughts or intentions of self-harm or suicide must be immediately managed by the DHSP under appropriate SME guidelines, a SME plan must be developed and the detainee referred for further assessment as required. For more information about SME (including in the absence of a clinician), refer to section 3.5 Psychological Support Program (PSP) in an IDF of this PI. As a further measure to mitigate potential risk for self-harm and suicide, any detainee identified as having PTSD or other conditions - such as moderate to severe depression, must be referred by the DHSP for treatment. The DHSP must obtain the detainees' informed consent prior to being referred for any treatment. If a detainee refuses to participate in a mental health review, the DHSP must record the refusal on the detainee's health care record. The DHSP must continue to offer further opportunities to the detainee to participate in screening, assessment and treatment if a detainee refuses.

Where cognitive impairment and mental illness is identified or suspected during screening, the DHSP should, as a priority, with the detainee's consent, provide follow-up health referrals to a mental health professional.

[5] *Framework for Suicide Risk Assessment and Management*, NSW Department of Health, Sydney, viewed 3 July 2023, www.health.nsw.gov.au

(such as a psychologist and/or psychiatrist) or in the case of cognitive impairment, to a General Practitioner (GP) for assessment and possible referral to a specialist. Follow-up care should also be provided and where appropriate, a documented mental health care plan. In order to identify detainees for whom earlier screening returned a false negative, or those who may have developed mental health problems while being in immigration detention, the DHSP is responsible for offering and administering scheduled mental health re-screenings. For more information on determining capacity to consent and processes for when a detainee is deemed not to have capacity to consent, refer to the Detention Health: Privacy, Consent and Medical Records – PI (DM-5925).

After the comprehensive mental health assessment has been conducted within 10-30 days of the detainee's arrival in an IDF, and it is identified that a detainee has serious, or complex mental health issues, the DHSP must ensure that a psychiatrist reviews the detainee and endorses the mental health care plan. Where possible, the review should occur in person, although in appropriate circumstances it may occur offsite via telehealth or, in exceptional circumstances, be done on the papers.

Any risks to the mental health or psychological health and wellbeing of the detainee identified by a mental health assessment must be taken into consideration by the DHSP in determining the appropriate mental health support and services for the detainee. The DHSP must also record the details on the detainee's mental health care plan and SME plan if developed, put in writing to the FDSP and follow the SME guidelines outlined in section 3.5.6 Supportive and Monitoring Engagement of this PI.

Where the FDSP or the Department make a mental health referral or request a mental health review, the DHSP must document the reason for (and any relevant context) in its nominated systems. The outcome of the referral or review must explicitly address each issue identified in the referral or request.

3.2.1 Mental health re-screening and assessment process

After the initial mental health screening and assessment, a scheduled mental health re-screening must be undertaken by the DHSP at six months, 12 months, 18 months and then at three monthly intervals thereafter for detainees in an IDF. At 18 months, the DHSP should ensure that a comprehensive assessment is undertaken by a psychiatrist. If a detainee refuses to participate in a scheduled mental health re-screening, the DHSP must record the refusal on the detainee's health care record.

3.2.2 Mental health considerations for quarantine and isolation placement decisions

Once a detainee enters quarantine or isolation in an IDF, a further mental health assessment must be undertaken by a DHSP mental health clinician as soon as practicable. This may include, but is not limited to, a review of the detainee's mental health history and may take place through a telehealth consultation. The impact of isolation on a detainee's mental health is to be considered during a detainee's quarantine or isolation. If there are any concerns with the impact that the detainee's isolation will have on the detainee's mental condition, more regular reviews with clinicians must be offered. Participation in mental health reviews will remain voluntary. If a detainee refuses to participate in a mental health review, the DHSP must record the refusal on the detainee's health care record. For more information on the escalation of isolation or quarantine placement decisions, refer to the Detention Health: Health Induction and Ongoing Health Screening – SOP (DM-3277).

Any risks to the mental health or psychological health and wellbeing of the detainee identified by a mental health assessment must be taken into consideration by the DHSP, in determining the appropriate mental health support and services for the detainee. Where a clinically indicated SME plan is developed, the DHSP must record the details on the detainee's mental health care plan, put in writing to the FDSP and follow the SME guidelines outlined in section 3.5.6 Supportive and Monitoring Engagement of this PI.

3.2.3 Ongoing health considerations for detainees involved in criminal justice or other legal proceedings

Detainees may be required to attend criminal justice or other legal proceedings during their time in an IDF, which may affect their health and wellbeing. The detainee's attendance may be organised either in person off-site, on site via Audio Visual link or via their personal phone. Where a departmental, a FDSP or a DHSP staff member is informed of any legal proceedings involving a detainee, this information must be shared with all participants in the local IDF site meeting to ensure appropriate arrangements can be implemented to support the detainee, if required. Where reasonably practicable, this information may include the provision of known court attendances by detainees to all participants in the local IDF site meeting. Appropriate arrangements may include additional health assessments or support before or after court attendance or throughout the course of criminal justice or other legal proceedings, as clinically recommended.

3.2.4 Awareness of cognitive impairment

Cognitive impairment is a term that includes intellectual disability, acquired brain injury, and confused states with associated limitations in memory, communication and social skills. Some of the associated symptoms include, but are not limited to:

- increased difficulty in environments with multiple stimuli (television, radio, conversation)
- difficulty holding new information in mind (recalling phone numbers or addresses just given or reporting what was just said)
- requiring frequent reminders to orient to the task at hand, confusion about time and place, and repetitive behaviour
- changes in behaviour (shows insensitivity to social standards, or makes decisions without regard to safety, increased irritability)
- becoming socially withdrawn or isolated[6].

The DHSP must screen for cognitive impairment during the HIA process using the MSE and consider any cognitive impairment issues in both the mental health and health care plan for the detainee. Where cognitive impairment or mental health illness is identified or suspected, the DHSP must refer the detainee for further assessment by a mental health professional, such as a psychologist or psychiatrist. In the case of cognitive impairment, a referral is to be made to a GP for assessment of possible referral to a specialist.

The DHSP must also provide appropriate advice on the supports required to ensure the safety, wellbeing and management of the detainee to the FDSP, the ABF and other departmental officers, such as SROs who are involved with managing the accommodation, welfare and casework for the detainee. The DHSP should be able to provide this information without compromising privacy obligations. This information must be shared between stakeholders such as the FDSP, the Department's SROs and relevant ABF Officer or ABF HWO at meetings including:

- the IMPRC
- the CCRC
- SME meetings that occur at each IDF as appropriate.

The FDSP must record relevant information (including the supports required to ensure the safety, wellbeing and management of the detainee) in the detainee's CIMP, Individual Management Plan (IMP) or if in place, the detainee's BMP. The FDSP must ensure that the detainee's privacy and confidentiality is maintained. For information on developing and reviewing IMPs and BMPs, refer to:

[6] *Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR),* Fifth Edition, Text Revision 2000, American Psychiatric Association, Washington, DC, viewed 30 June 2023, www.psychiatry.org.

- Detention Services Manual – Program and activities- Individual management plan and review – PI (DM-4842)
- Detention Services Manual – Safety and security management – Behaviour management – PI (DM-5027).

3.2.5 Vulnerable persons

A vulnerable person is a person who, due to any condition or circumstance, has a reduced capacity to look after or manage their own interests. Whether a person is vulnerable can depend on both the situation and resilience of the individual concerned. Vulnerability can be either temporary or ongoing. Please refer to Vulnerable Persons – SM (SM-5337) for further information on vulnerable persons.

The DHSP must consider that some detainees in IDFs may be particularly at risk of developing a mental illness. If a detainee is identified as being at risk of developing a mental illness, the DHSP must take the appropriate steps to clinically assess, evaluate and treat any mental illness condition. This includes the preparation of a documented mental health care plan, referrals to appropriate psychological support services and mental health re-screenings as recommended by an appropriate mental health clinician.

Relevant mental health support information for detainees with known vulnerabilities must be recorded by the DHSP into any CIMP or SME plan in place and by the FDSP into the detainee's CIMP or if in place, the detainee's BMP, to ensure the safety, wellbeing and management of the detainee and keeping in mind that the detainee privacy and confidentiality is maintained. For more information, refer to Detention Health: Privacy, Consent and Medical Records – PI (DM-5925).

3.2.6 Challenging behaviour

While in an IDF, detainees may experience a range of emotions that can contribute to detainees engaging in antisocial or challenging behaviour. A range of other factors can also influence a detainee's behaviour, including underlying and/or undetected physical or mental health issues, cognitive impairment, and the influence of licit or illicit drugs, alcohol and other substances. Such behaviours have the capacity to impact on the well-being of the detainees and other persons in the IDF and can undermine the safety and good order of an IDF.

In the delivery of mental health treatment and services to detainees, as well as in general interactions with those affected, FDSP staff in consultation with the DHSP, must seek to de-escalate where appropriate any challenging behaviour that could impede treatment and safety or cause damage or harm to the detainee and/or others.

Challenging behaviour may include:

- property damage
- intimidation and/or stand over tactics
- grooming of others
- non-peaceful protest/obstructive behavior
- verbal abuse or inappropriate use of coarse language
- intrusive behaviour
- threats or incidents of physical violence
- inappropriate sexual behavior
- cyber harassment or vilification.

3.2.7 Managing and preventing challenging behaviour in an IDF

Any FDSP staff member who is interacting with, or witnesses, a detainee exhibiting challenging behavior involving a detainee/s with suspected or diagnosed mental illness, must make all reasonable efforts to de-escalate the behaviour if it is safe and appropriate to do so. De-escalation techniques must be undertaken with a trauma-informed and safe approach and clear communication, and must attempt to address the detainee's immediate needs. De-escalation techniques can include:

- responding to identified needs, for example arranging for review of medications
- providing adequate personal space (the physical space immediately surrounding someone)
- encouraging reason and calm
- listening carefully with empathy and respect and/or
- use of a low stimulus environment (for example, a quiet space away from the general detainee population).

On occasion, the escalation of challenging behaviour may relate to hypervigilance and reactivity to trauma related cues.

If the detainee's behaviour poses a serious risk to others, then minimising this risk should be the priority. FDSP staff must be trained in de-escalation techniques and aware that fear and distress can manifest as hostility, which may be amenable to de-escalation. De-escalation of challenging behaviour is to be conducted as reasonably as possible (noting the expertise of the FDSP), in order to maintain and balance the safety and security of the detainee and others. Where required, additional support services such as DHSP mental health clinicians or external support services such as police or ambulance should be utilised. If emergency services are called then the FDSP or the relevant ABF officer must undertake incident management reporting activities, in accordance with the Detention Services Manual – Safety and security management - Incident response and management – SOP (DM-3303). Refer to Detention Services Manual – Safety and security management – Incident management and reporting – PI (DM-616) for further information on challenging behaviours that require incident management reporting.

FDSP staff must continue to be alert to detainees ideating, verbalising or actualising of self-harm risk and refer the detainee to the DHSP as required. If clinical advice is required after clinical hours or during the weekend, FDSP staff should employ Keep SAFE (Support - Action Follow-up - Evaluation) and/or escalate for discussion with the DHSP mental health nurse on the DHSP Health Advisory Service (HAS) line.

Please refer to Detention Services Manual - Safety and security management – Behaviour management – PI (DM-5027) for further information on processes to follow if a detainee is displaying such behaviour.

In consultation with the Department and the FDSP, the DHSP must arrange any nursing, allied health, psychological or additional medical services that may assist in treating and/or managing any mental health issues that may be contributing to challenging behavior. This information should be detailed in the detainee's mental health care plan. The DHSP must also provide this information to stakeholders such as the FDSP, the Department's SRO and nominated ABF Officer or ABF HWO at:

- the SME daily meeting
- the IMPRC, or
- CCRC meetings that occur at each IDF.

The sharing of this information should be undertaken without compromising a detainee's privacy. This information should also be documented in the detainee's IMP, and if in place, the detainee's BMP. The FDSP should refer serious instances of challenging behavior, including situations in which staff or a detainee are put in danger or risk of harm, for rapid medical or security intervention, as required. Please refer to the Detention Services Manual - Incident management and reporting – PI (DM-616*)* for further information on challenging behaviours that require incident management reporting.

In dealing with a detainee who has a suspected or diagnosed mental illness, cognitive impairment or substance abuse issues, the DHSP must ensure that appropriate treatment and care planning is implemented through the HIA and/or mental health treatment sessions related to general mental health, in order to mitigate instances of challenging behaviour potentially caused by mental illness. The DHSP should take into account the individual circumstances of the detainee and any personal or medical requirements.

3.3 Mental health trauma services in an IDF

Mental health treatment and services in immigration detention are tailored to the needs of the individual detainee and based on clinical assessment and advice. The potential for the experience of immigration detention to compound psychological damage caused by previous torture and trauma, requires a carefully considered response by health services and other staff working in the immigration detention environment.

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

Trauma can arise from single or repeated adverse events that threaten to overwhelm a person's ability to cope. Trauma may adversely affect a person's health, wellbeing, emotions, relationships and sense of self and identity.

When the trauma is repeated and extreme, occurs over a long period, or is perpetrated in childhood by trusted persons, it is referred to as complex trauma. Complex trauma can affect not only the individual who has experienced it directly, it may also affect their family members and loved ones[7]. Trauma-related mental health problems could arise from experiences including:

- torture or persecution
- exposure to high levels of conflict and violence
- physical and sexual violence
- domestic violence
- witnessing an act of violence
- death of a loved one or friend
- crime
- road traffic and other accidents
- natural and technological disasters and/or
- terrorist attacks.

The effects of trauma may be varied and the person experiencing mental health distress may not recognise the adverse effects on their physical and mental wellbeing, as being directly linked to a traumatic event.

[7] *Trauma informed practice,* Mental Health Australia, Canberra, viewed 30 June 2023, www.mhaustralia.org.

Emotional and psychological symptoms[8]	Physical symptoms
• Shock, denial, or disbelief • Confusion, difficulty concentrating • Anger, irritability, mood swings • Emotional distress at reminders of the trauma • Excessive vigilance and reactivity to potential future threat cues • Anxiety and fear • Guilt, shame, self-blame • Withdrawing from others • Feeling sad or hopeless • Feeling disconnected or numb	• Insomnia or nightmares • Fatigue • Being startled easily • Difficulty concentrating • Racing heartbeat • Edginess and agitation • Aches and pains • Muscle tension

3.3.1 Assessing those with trauma related mental health issues

Detainees entering onshore immigration detention will undergo comprehensive health screening to identify mental health issues and other presentations, indicating a possible history of torture and trauma. Referrals must be made for specialist assessment where clinically indicated.

The DHSP will use mental health screening practices to identify mental health issues, including the effects of trauma, and to consider these factors within a mental health care plan for the individual.

Additional sources of information may be utilised in the assessment of trauma based mental illness – such as observations from the DHSP and recorded observation notes.

3.3.2 Model of care

The DHSP 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 mental health clinician or counsellor who are appropriately registered to practice within Australia and are subject to oversight by the relevant governing body:

- is registered with the Australian Health Practitioner Regulation Agency (AHPRA) or professional association/body, and
- has completed relevant clinical training in identifying and/or responding to survivors of torture and trauma, and
- has relevant experience in the field of trauma, and
- is trained and skilled in the clinical competencies required to deliver evidence based treatments for trauma related disorders.

[8] *Emotional and Psychological Trauma*, Lawrence Robinson, Melinda Smith, M.A. and Jeanne Segal, Ph.D., 27 February 2023, HelpGuide, Australia, viewed 30 June 2023, www.helpguide.org.

These professional qualifications will provide a level of assurance that quality care is delivered by skilled clinicians or counsellors, who are trained to professional standards and whose practice is subject to oversight by a professional body.

The DHSP will detail the reasons for a referral within the referral to the specialist clinician or counsellor. Likewise, the DHSP as the referring health service, will need to know what specialist treatment plans are in place and what continuing therapy is recommended.

This model of care must be supported by an active health promotion program developed by the DHSP. This may include group counselling and/or therapy sessions, health information, preventative care, trauma informed care and health education.

All mental health trauma services must be provided onsite for those in an IDF, unless it is not reasonable or practical to do so. Where detainees are located in an APOD, their treatment is provided by mental health clinicians or counsellors at the nearest IDF or clinic set up in an APOD. If detainees in RD disclose a history of torture and trauma to their SRSS Provider, or the SRSS Provider reasonably believes a referral for torture and trauma services is required, the SRSS Provider must organise an appointment with the detainees' preferred GP clinic contracted by the DHSP. For more information, refer to section 9.12 of SRSS OPM.

3.3.3 Mental health treatment sessions

The availability of specialist trauma services treatment sessions for detainees is to be consistent with the Australian community standards. In order to access these services, detainees in IDFs must be referred by the DHSP clinician managing the detainee's mental health. A referral for mental health services should be in writing. For further information in relation to comparable mental health services available in the community please refer to the Medicare Benefits Schedule[9] for further guidance.

3.3.4 Children and adolescents

It is important to be aware that children and adolescents may experience or witness trauma and their responses to these experiences will vary depending on age and the level of support they receive. Children often choose not to, or are unable to verbalise their experiences of trauma. In such cases, the DHSP must take reasonable steps to obtain assistance from mental health clinicians with expertise in working with traumatised children and adolescents. If a mental health clinician is unavailable please refer to section 3.5.18 Supportive monitoring and engagement in the absence of a mental health clinician in this PI.

The DHSP must ensure that information pertaining to the trauma experienced by the child or adolescent is included as part of the Health Discharge Summary (HDS) report, to support well-informed, prompt and appropriate continuity of care for the child and their family. For guidance relating to the care and support of children and their families refer to the Child Safeguarding Framework – PS (BE-916) and Best practice for interacting with Children – PI (BC-764).

3.4 Self-harm and suicide in IDFs

The Department places the highest priority on preventing self-harm and suicide in IDFs. See the Department's policy statement in the Detention Health: Suicide Prevention Framework (HR-4893) and refer to the NSW Health, Framework for Suicide Risk Assessment and Management[10].

[9] *Medicare Benefits Schedule,* Department of Health and Aged Care, Canberra, viewed 30 June 2023, www.health.gov.au.
[10] *Framework for Suicide Risk Assessment and Management*, NSW Department of Health, Sydney, viewed 3 July 2023, www.health.nsw.gov.au

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

Food and/or fluid refusal can be self-harming behaviour; however, those behaviours will not be managed using SME, unless a clinical assessment indicates that use of the SME is necessary. For further instruction on responding to and managing food and/or fluid refusal, please refer to Detention Health: Food/Fluid Refusal – PI (DM-1451).

3.4.1 Risk factors for self-harm and suicide

Generic risk factors include:

- history of self-destructive behaviour (including deliberate self-harm)
- demographics (for example: male, old age)
- longstanding or recently diagnosed medical illness
- known psychiatric illness, particularly:
    - mood disorders
    - psychotic disorders
    - drug and alcohol disorders
    - past and current traumatic experiences, with or without a diagnosis for PTSD
    - co-occurring mental illness and substance abuse.
- significant loss (for example: bereavement)
- being a victim of crime, including physical or sexual assault
- history of self–harm
- history of harm to a family member/friend/close contact in the past (including war or natural disasters in a person's home country).

Risk factors that may apply to detainees in immigration detention include:

- exposure to past torture or trauma, which has been found to increase the likelihood of suicide among immigration detainees
- time in immigration detention, which may correlate with the rates of mental illness and the severity of mental distress in individuals
- uncertainty of status resolution pathway
- criminal charges and/or court proceedings
- social isolation, including separation from family and significant others
- witnessing, or being involved in, group self-harming or destructive behaviours
- attempted suicide or attempted or actual self-harm
- for an individual with other risk factors - awareness of attempted or actual self-harm or suicide by other detainees
- 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
- increased risk around religious holidays
- loss of hope.

3.4.2 Warning signs

A full appreciation of the range of potential warning signs is equally complex and should be explored in mental health and suicide prevention training, which is mandatory for all departmental and service provider staff working in IDFs. Warning signs may include:

- expressed feelings of guilt or shame
- emotional stress
- deterioration of personal hygiene
- statements suggesting feelings of hopelessness or helplessness
- anxiety and depression
- agitation
- social isolation or withdrawal
- threats or talk of suicide or self-harm
- giving away many or all belongings
- reduced interest in or refusal of food or drink.

3.4.3 Protective factors

A protective factor is any factor associated with a reduced likelihood of a disease, condition or event. Wherever possible, departmental policy should seek to strengthen these protective factors for all persons in IDFs. Protective factors enhance resilience and may offset risk factors. Although there is no specific research on protective factors for detainees at risk of self-harm and suicide in IDFs, protective factors for self-harm and suicide include:

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

3.5 Psychological Support Program in an IDF

The PSP provides an overarching framework for clinically recommended approaches to identifying and supporting detainees who are at risk of self-harm and suicide. The PSP is designed to support detainees and also reduce uncertainty and stress for staff dealing with detainees, who exhibit self-harming and/or suicidal behaviour.

All detainees are placed on the PSP, which commences at reception and continues while they remain in an IDF.

The PSP is a framework with clinically informed interventions to assist in the management of a detainee's risk of self-harm and suicide. The program is managed on a day-to-day basis by the SME review participants, led by a mental health clinician from the DHSP and supported by representatives from the FDSP and the Department (including the ABF and Status Resolution). SME is a component of the PSP and details the different risk levels (with corresponding monitoring and engagement requirements) for managing detainees, identified as being at risk of self-harm or suicide.

All SME review participants are expected to:

- work together to provide an environment that seeks to prevent self-harm by reducing risk factors and enhancing protective factors.
- work together to ensure that there are activities and programs targeted at mental health promotion and prevention.
- work together to implement suicide bereavement and postvention strategies to minimise the possible flow-on effect on others within the detention environment.
- participate in relevant SME review meetings and processes, including case reviews.
- share information about issues that may impact on the safety and wellbeing of the detainee or any service providers or departmental officers.
- keep complete, comprehensive, consistent, accurate and timely records.

3.5.1 PSP related meetings

The following table outlines the key meetings that support the PSP.

Meeting	Purpose	Frequency	Chair	Core Participants
Local IDF site morning meeting	Sharing of information and management of detainees onsite at an IDF.	Daily	ABF Superintendent (Detention Facility)	• ABF Detention Inspector • Operations (Facility) • Child Wellbeing Officer where minors are involved • SRO • FDSP • DHSP
SME review meeting	Guide the management of detainees where	Daily (on weekdays)	DHSP	• Led by a DHSP mental health clinician

	there is a risk of self-harm or cause for concern.			• Departmental officers (including a nominated ABF Officer or ABF HWO) • Child Wellbeing Officer where minors are involved • ABF Detention Health Operations • SROs • FDSP Facilities Operations Manager
Clinical Case Review Committee meeting	Provide a forum to discuss, refer and/or escalate urgent and/or complex medical cases in immigration detention to ensure they are appropriately managed, in accordance with relevant therapeutic guidelines, departmental policies and relevant expectations and obligations.	Fortnightly	Clinical Advisory Team (CAT)	• Chief Medical Officer (if able to attend) • a Medical Officer of the Commonwealth • Registered Nurse from Immigration Health Branch • representative from Detention Health Operations Section • representative from Regional Processing Health • DHSP • Offshore Health Service Provider
Individual Management and Placement Review	Provide professional, balanced, timely and confidential advice to Facility	Weekly	ABF Superintendent (Detention Facility)	• FDSP • DHSP Health Services Manager and/or

Committee (IMPRC)	Management regarding care and accommodation issues, in relation to detainees placed at the Facility.			Mental Health Team Leader • SRO • ABF Detention Inspector • Operations (Facility) or ABF Superintendent (Facility) • Child Wellbeing Officer where minors are involved

3.5.2 PSP in practice (in an IDF)

The PSP process commences for *all* detainees in IDFs at reception and continues while a detainee remains in an IDF.

PSP occurs within the framework of a mental health assessment process, which includes scheduled and triggered re-screening as documented separately in Detention Health: Health Screening and Management - PI (DM-6138).

The following table provides a high-level overview of the PSP process.

	Stage	Who	Timing	Tool(s)/ supporting processes
1	Self-harm assessment interview on entry into immigration detention	FDSP	On reception	Initial self-harm assessment.

	Stage	Who	Timing	Tool(s)/ supporting processes
2	Comprehensive mental health screening and assessment	DHSP or relevant state/territory tertiary health provider as required	Initial preliminary screening within 72 hours and a more comprehensive universal screening within 10-30 days unless expedited due to identified risk. Note: screening processes and timings are outlined and conducted in accordance with Detention Health: Health Screening and Management – PI (DM-6138).	A range of screening and assessment tools and processes.
3	Management of self-harm risk under the PSP	SME review participants (DHSP Health Services Manager and/or Mental Health Team Leader), FDSP, SRO and nominated ABF Officer or ABF HWO and including Child Wellbeing Officer, where minors are involved.	In response to identified risk of suicide or self-harm (including actual incidents of self-harm or attempted self-harm or suicide) upon entry into, or at any point during detention in an IDF.	SME plan, SME review meetings, CCRC meetings, other clinical records.

3.5.3 PSP process in detail

The following table provides a *detailed description* of PSP process.

	Stage	Who	Description
1	Risk identified	FDSP, DHSP, the Department, family, friends, advocates	Risk of self-harm is identified either through formal screening and assessment, self-referral, or referral from a concerned party, including another detainee.

	Stage	Who	Description
2	Referred for SME assessment	DHSP, FDSP, SRO and/or nominated ABF Officer or ABF HWO	In managing the immediate needs of those at risk of self-harm or harm to others, the FDSP must: • act immediately to ensure the safety of any detainee • place the detainee under immediate observation, and • advise the Department of the identified detainee and actions taken. Concerns are formally recorded, and the case is referred to a DHSP mental health clinician. If a DHSP mental health clinician is available, they will make an assessment of the risk of self-harm. The process continues to Stage three. If a DHSP mental health clinician is not available, commence Keep SAFE, and escalate to FDSP Facility Operation Manager (FOM) and relevant ABF officer or if outside clinical hours the ABF Duty Officer to determine if the detainee can be placed in a safe environment onsite, until a clinician is available. Advice may be sought from a DHSP mental health nurse by phone from the Health Advice Service (HAS) line. If possible, the detainee will be placed in a safe environment onsite, until a mental health clinician arrives to assess the risk of self-harm. If placement in a safe environment within the IDF is not a suitable option, consider arrangements to transfer the detainee to hospital (with the detainee's consent). If the detainee does not consent, assess what further action may be required pending the arrival of a mental health clinician. Note: Please refer to Detention Services Manual - Detainee placement – Closer supervision and engagement of high-risk detainees (High care accommodation) – PI (DM-626) for further information if high care accommodation is required.

	Stage	Who	Description
3	Monitoring and engagement	DHSP, FDSP, SRO and nominated ABF officer or ABF HWO	The DHSP mental health clinician develops the SME plan appropriate for the identified level of risk and must share and discuss the plan with SME review participants (FDSP, SRO and nominated ABF Officer and including Child Wellbeing Officer, where minors are involved). Responses can be adjusted to suit the changing levels of risk. Any changes made to the SME plan by DHSP must be recorded on the detainee's mental health care plan and put in writing to the SME review participants.
4	Post-incident response	DHSP (particularly the mental health team) and FDSP	If a self-harm incident occurs, post-incident response arrangements are implemented as per Detention Health: Responding to Self-Harm – SOP (DM-3283).
5	Scheduled reassessment of self-harm risk	DHSP	Self-harm risk is reassessed as part of scheduled mental health re-screening arrangements or when triggered by risk factors or warning signs.

3.5.4 Initial self-harm assessment interview

The FDSP is required to complete a self-harm assessment interview with detainees within 12 to 48 hours after arrival, in accordance with detainee reception and induction requirements. For further information about reception and induction guidelines, please refer to Detention Services Manual - Detainee entry and exit — Reception and induction of detainees – SOP (DM-3252).

This process requires the FDSP to request all persons entering an IDF (other than young children accompanied by their parents) to participate in a self-harm assessment interview. If dealing with an UAM, further guidance relating to the care and support of children and their families can be obtained by referring to the Child Safeguarding Framework – PS (BE-916) and Best Practice for Interacting with Children – PI (BC-764).

The purpose of the interview is to collect information that could be important in identifying risk of self-harm. Collecting information is only useful if that information is acted upon. If the FDSP has any concerns for the person's safety, they should immediately take steps to obtain advice from the DHSP.

The interview process should not be attempted where the FDSP assesses the detainee is highly distressed or agitated. In such cases, refer the person immediately to a DHSP clinician or place them on Keep SAFE in the interim, whilst maintaining close monitoring and engagement.

The FDSP must undertake a self-harm assessment interview with the detainee and record the detainee's responses against the interview questionnaire. Interview notes recorded by the FDSP interviewer must be provided to the clinician undertaking the HIA or, if the assessment indicates a more serious risk, the FDSP officer should immediately contact the DHSP or an emergency health service (including an ambulance, if required). The FDSP must record the interview transcript, including any follow up action taken in the detainee's case file. Informed consent must be obtained from the detainee prior to conducting the HIA, and any other screening or medical treatment, including the self-harm assessment interview. In offering an initial self-harm assessment, the FDSP is to explain the purpose and importance of the assessment and discuss

the process to enable the detainee to make an informed decision. Access to an interpreter is to be provided if required.

If the detainee refuses, the FDSP will record the refusal on the detainee's case file and advise the DHSP.

For further information on determining capacity to consent and processes for when a detainee is deemed not to have capacity to consent, please refer to the Detention Health: Privacy, Consent and Medical Records – PI (DM-5925).

Regardless of whether the detainee consents to the self-harm assessment interview, the FDSP staff member must take reasonable steps to respond to concerning behaviours (including challenging behaviours and/or symptoms of trauma), document these on the detainee's case file and record any action taken in response. The FDSP must also raise these concerns at the daily local IDF site meeting so that all SME review participants are aware of any potential self-harm risk.

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

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

3.5.5 Identifying emerging cases of concern

All SME review participants have a responsibility to identify detainees of concern. This may include detainees who are not currently on SME, such as those who may be impacted by external events, for example, a negative immigration status outcome or ongoing legal proceedings), or those who are displaying negative or changed/out of character behaviour. The SME review participants should consider the detainee's history and behaviour, any current behavioural management plans in place and whether the detainee may benefit from increased monitoring and engagement with consideration of additional intervention, if appropriate. These issues should be discussed at either or several of the following forums:

- SME meeting
- the IMPRC
- the CCRC meeting.

The relevant secretariat must document and record any issues that have been raised.

Detainees who may be of concern and who are discussed at any of the above listed meetings must be recorded on a 'watch list'. The 'watch list' must be maintained and regularly updated by the ABF Superintendent (Facility) and shared with all SME review participants. A detainee may be removed from the 'watch list' with endorsement of all three core SME review participants: the FDSP Facilities Operations Manager, the DHSP and the nominated ABF Officer or ABF HWO.

A detainee who continues to be of concern, and regardless of whether they are on a 'watch list', can be referred at any time, by any stakeholder, to the DHSP for a mental health assessment, in which the risk of self-harm can be comprehensively reassessed. The DHSP must undertake the assessment(s) and decide whether to place the detainee on SME. The DHSP must then discuss the outcomes and proposed SME risk level, with relevant SME review participants such as the FDSP Facilities Operations Manager, nominated ABF Officer or ABF HWO and representatives from Detention Health Operations and Status Resolution and record in a SME management plan. A copy of the plan must then be scanned by the DHSP onto the detainee's health record, mental health care and health care plans. For more information on SME levels and monitoring timeframes, refer to section 3.5.6 Supportive Monitoring and Engagement of this PI.

3.5.6 Supportive Monitoring and Engagement

SME is an extension of the engagement that occurs on a daily basis between staff and detainees in an IDF. SME aims to support detainees who may be vulnerable and in need of additional positive engagement. For more information in relation to SME guidelines, refer to section 3.5.9 Self-harm Risk Levels of this PI.

3.5.7 SME review meeting

The day to day management of detainees on SME is undertaken by a lead DHSP mental health clinician and supported by SME review participants from the FDSP (Facilities Operations Manager), the ABF (Detention Inspector), Operations (Facility) and representatives from Detention Health Operations and Status Resolution.

A multi-stakeholder approach is essential because, while decisions about the management of detainees at risk of self-harm are led by mental health clinicians, the FDSP interacts most frequently with detainees at risk of self-harm, and ABF IDF Facility and Status Resolution staff may also have regular contact. The purpose of this approach is to provide the opportunity for all concerned parties to share information regarding detainee wellbeing, based on their individual interactions.

The DHSP mental health clinician must lead and discuss proposed changes to a detainee's SME risk level and response (including where external clinical assessment by a mental health clinician is required). The DHSP must document the minutes relating to the discussion in the DHSP PSP meeting template, including documentation of stressors/concerns, updates and actions. The DHSP must distribute the minutes and the SME plan to SME participants such as the FDSP Facilities Operations Manager, ABF Detention Inspector, Operations (Facility) and representatives from Detention Health Operations and Status Resolution via email and save the minutes in the nominated record keeping system. This requirement is in place to ensure all parties are aware of the decision being made. The only exception to discussing the proposed changes to the SME risk level with SME review participants, prior to a decision being made, is where delays in accessing the views of one of the SME review participants would delay critical action.

All SME review participants are required to be aware of any required actions allocated to them in relation to any changes on a detainee's SME plan. Any disagreement among the SME review participants over the DHSP's decision or change in relation to a detainee's SME risk level must be noted by the DHSP in the minutes of the daily SME meeting and recorded in the detainee's mental health care plan. The DHSP mental health clinician leading the SME review meeting must scan a copy of the minutes into the detainee's health record as soon as practicable after conclusion of the meeting.

For more information in relation to the review of SME risk levels outside clinical hours or during the weekend, refer to section 3.5.9 Self-harm Risk levels and to section 3.5.20 Supportive monitoring and engagement responses without a mental health clinician in this PI.

The participants of the SME review meeting depend on the circumstances of the individual case in question, but must include:

- a DHSP mental health clinician, who will act as the SME review leader
- the FDSP FOM
- departmental staff who are required to contribute to appropriate care and management of the detainee (either SRO or ABF Officer, depending on who adopts the primary client support role)
- (at request of the DHSP SME review leader) any ABF or contracted staff who may provide useful information and input, especially those who have had direct contact with the detainee at risk of self-harm.

The SME review participants must meet as frequently as the DHSP clinically determines as necessary to guide the management of those cases, where there is a risk of self-harm by a detainee. Each SME review meeting should be minuted, with any assigned actions and responsibilities noted accordingly. The DHSP

should ensure that the minutes are provided to all SME review participants for review and are saved in the detainee's mental health care plan, in the relevant electronic record management system operated by the DHSP.

Non-clinical participants of the SME review meeting do not need to know detailed diagnoses or other clinical information of a personal nature, in order to participate in the review. The DHSP is only required to provide general health summaries, risk assessments and recommendations or decisions in relation to matters that may impact on the detainee's health and safety or the health and safety of other people (staff, other detainees and visitors). Decisions about the level of private health information that should be shared in SME review meetings must be made by the DHSP, in accordance with professional standards and its obligations under the *Privacy Act 1988*.

Any requests for access to health information in excess of that provided by the DHSP, or concerns regarding privacy and confidentiality requirements, should be sent to Detention Health Operations (detention.health@abf.gov.au).

3.5.8 Safe placement arrangements

In considering whether a detainee can be safely accommodated within an IDF, FDSP and ABF IDF staff need to determine whether the usual placement area of the detainee, or any of the other available placement areas, offer a safe environment. In order to determine whether a safe environment within the IDC is available, the FDSP, in consultation with ABF IDF staff, will need to ensure that the detainee can be constantly observed and monitored by the FDSP.

High care accommodation can be considered for detainees for whom relocation from the general detainee population has been clinically recommended. High care accommodation refers to an environment where closer supervision and engagement of the detainee can be maintained. Please refer to Detention Services Manual - Detainee placement – Closer supervision and engagement of high risk detainees (High care accommodation) – PI (DM-626) for further information on high care accommodation arrangements.

3.5.9 Self-harm risk levels

There are five self-harm risk levels, depending on the severity and imminence of risk. Broad guidelines for the assessment of each SME risk level are provided in the following table. Importantly, these guidelines are provided as a high-level guide only. Health professionals are trained in risk assessment and are to use clinical judgement in each situation. The assessment guidelines are potential examples, and are not intended to be an exhaustive list of the circumstances in which the risk level may be appropriate. It is imperative for these guidelines to be flexible and for the facts of any particular case to govern how a detainee is treated.

Item	Risk level	Assessment guidelines
1	**High imminent**	For consideration where: • a detainee has expressed clear plans to attempt serious self-harm or suicide • there is a high level of expressed intent to make an attempt of serious self-harm or suicide • the detainee's level of psychological distress is so severe that a mental health clinician believes there is a high risk of an attempt of serious harm or suicide, and/or • a clinician considers that constant in line of sight monitoring and engagement is necessary to prevent serious self-harm or suicide. Time limits apply to the use of high imminent risk of self-harm. Refer section 3.5.14 'High imminent' risk level – 24 hour limit in this PI.
2	**High**	For consideration where: • a detainee has expressed clear plans to attempt serious self-harm or suicide • there is a high level of expressed intent to attempt serious self-harm or suicide • the detainee has a high level of psychological distress and mental health clinicians believe there is a high risk they may attempt self-harm or suicide, and/or • a mental health clinician considers that 15 minute monitoring and engagement is necessary to prevent serious self-harm or suicide.
3	**Moderate (imminent)**	For consideration where: • a detainee may have threatened self-harm or expressed ideas of hopelessness, but has not engaged in serious self-harming behaviour, and/or • a clinician believes that an increased level of scrutiny is warranted, but that constant in line of sight monitoring would contribute to the level of distress or is unnecessary.

Item	Risk level	Assessment guidelines
4	**Moderate (chronic)**	For consideration where: • a detainee may have previously engaged in self-harming behaviour or has a pattern of threatening self-harm, but is assessed as unlikely to have serious active or short term suicidal intent • a clinician believes that some level of observation is warranted, but that intrusive monitoring and engagement would contribute to the level of disturbance, and/or • a detainee who has had a recent adverse visa outcome or court decision.
5	**Low (ongoing)**	For consideration where: • a detainee is being stepped down from higher SME risk levels • a detainee may have a diagnosed (but treated) mental health condition • a detainee has not previously engaged in self-harming behaviour or threatened self-harm • a detainee has a family history of mental illness • a detainee has disclosed or may have been exposed to torture and/or trauma • a detainee is on the 'watch list' and is not already on SME.

During clinical hours and where possible, the initial SME risk level is determined by a member of the DHSP mental health team or another qualified mental health clinician following an in person assessment. If the detainee is in quarantine and/or a mental health clinician is not available on site, then a telehealth assessment may be arranged by the DHSP for low risk cases.

If an initial SME risk level determination is required after clinical hours or during the weekend, then the FDSP is to discuss the case with the DHSP mental health nurse on the HAS line for advice as to whether an in person assessment is required by a member of the DHSP mental health team or another qualified mental health clinician. If the detainee is in quarantine and/or a mental health nurse on the HAS line determines the case to be low risk, then a telehealth assessment may be arranged by the DHSP.

If a DHSP clinical review of High risk SME risk levels is required after clinical hours or during the weekend the DHSP is to make arrangements for an in person clinical assessment. Where a detainee is deemed to be at high risk and it is proposed to reduce the level of monitoring, an in person clinical assessment must be undertaken or arranged by the DHSP. In the absence of the DHSP making prior arrangements for an afterhours clinical assessment, and where a clinical review is due for high risk cases, the DHSP mental health nurse on the HAS line must engage with the FDSP Facilities Operations Manager and the ABF duty officer to make arrangements for an in person assessment.

The SME risk level determined by the DHSP mental health clinician is to be noted and discussed with all participants of the daily SME review meeting before being implemented, with the exception of high risk cases

requiring immediate action. If necessary, further discussions may occur at this meeting, but the final determination of the SME risk level is a matter for the mental health clinician.

At the next available SME review meeting, the SME review participants must be advised of changed SME risk levels and record the discussion in the meeting minutes. The initial risk assessment outcome and the SME risk level must be documented in minutes and scanned into the detainee's mental health care plan.

For further guidance on detainees who are, or may be, at risk of self-harm and/or suicide where there is no DHSP mental health clinician immediately available to conduct an assessment of risk, refer to section 3.5.19 Supportive monitoring and engagement without a mental health clinician of this PI.

3.5.10 Monitoring and engagement within SME

Monitoring and engagement techniques are tailored to the level of risk attributed to a detainee in regards to self-harm or suicide. They are aimed at keeping the detainee safe through a process of SME and could be varied as necessary based on a mental health clinician's assessment of the mode of monitoring and engagement. These individual measures for monitoring and engagement are to be comprehensively dealt with by the DHSP mental health clinician in the SME plan for the detainee, including SME requirements while the detainee is awake or asleep. In the development of the SME plan, the DHSP mental health clinician is to discuss with all respective SME review participants and consideration needs to be given by all participants to any cultural and/or special requirements vulnerable detainees may have to ensure their safety, health and welfare needs. The updated SME plan is then recorded by the DHSP in the detainee's mental health record and confirmed in writing for all respective SME review participants, via approved email addresses.

SME should emphasise:

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

When undertaking observational methods of monitoring, the FDSP must provide detailed, written observations that are meaningful and include information about a detainee's mood, what they said and their behaviours. Where possible, the FDSP is to encourage the detainee to maintain contact with outside social supports such as family, friends and cultural/religious figures where these supports are deemed to be a protective factor, and to continue with phone calls, exercise and activities. Those on High Imminent SME should, where they indicate a desire to do so, be allowed access to family or other social supports. However, these individuals do not replace the need for FDSP observation.

The FDSP must ensure comprehensive handovers at changes of shift. Incoming FDSP staff must be fully briefed and continue the monitoring and engagement plans, developed by the SME mental health clinicians. It is the responsibility of the FDSP shift managers to ensure that SME plans are adhered to. Monitoring and engagement is preferably direct human-to-human contact. It is important to engage with the person without being intrusive or demanding. In situations where the detainee poses a risk to officers (identified by the DHSP and/or FDSP), observational methods of monitoring may be adjusted for safety reasons on an individual basis and as decided by the FDSP Duty Operations Manager in consultation with the DHSP.

In instances where the detainee uses a toilet or bathroom, the FDSP should make a note of any prolonged absence and ensure that appropriate action is taken. If the detainee is at such risk to themselves they cannot use the toilet or bathroom on their own, then the DHSP must undertake an immediate clinical review and consideration must be given to alternative arrangements and/or placement for the detainee.

Where skilled, minimally intrusive, approaches to waking are clinically recommended then this should occur without undue noise, physical contact and through use of the person's name or minimal change in light and

ambience. The observing FDSP or DHSP officer needs to be confident that the detainee's respirations, colour and position is consistent with sleep rather than an altered conscious state.

When choosing a primary support person (from the FDSP), the FDSP must consider whether there is a good match or an existing relationship of trust that would maximise the effectiveness of monitoring and engagement and to also consider the detainee's preference. Consideration may be given to the detainees' biological sex preference for a support person however, where no preference has been indicated, detainees should generally be paired with a support person of the same biological sex, where possible. In situations where this is not possible, decisions should be made in consultation with ABF Detention Operations.

Monitoring and engagement by the FDSP should be direct in person contact, unless alternative methods have been clinically determined to be appropriate, such as for safety purposes. However, engagement may also occur through a mix of direct in person contact or phone calls.

3.5.11 Monitoring timeframes

Monitoring timeframes are tailored to the level of risk attributed to a detainee in regards to self-harm or suicide. They are aimed at keeping the detainee safe through a process of SME and encouraging their reintegration with the wider detention population, in instances where the detainee has been relocated to alternate accommodation (such as High Care or a hospital).

The FDSP is required to provide detainees on SME with a supportive environment that facilitates positive outcomes for the detainee, in line with the ongoing consultation and advice of the DHSP.

The timeframes in the table below are targeted towards detainees who pose a risk of self-harm or suicide. These monitoring timeframes are a high level policy guide, and may be varied as necessary based on a mental health clinician's assessment. These individual measures for monitoring and engagement must be comprehensively dealt with by the DHSP in the SME plan for the detainee, including clinical advice for when the detainee is awake or asleep. The DHSP is to outline measures such as the method of meaningful engagement (for example talking with the detainee) and observational methods of monitoring (for example physical distance to be maintained from the detainee) required by the FDSP for each SME risk level. The DHSP is to update and record the developed SME plan in the detainee's mental health record and discussed and confirm in writing to all respective SME review participants via email.

The five levels of monitoring and engagement are:

Level	Description	Clinical Review
Constant line of sight – monitoring (High Imminent)	Constant line of sight monitoring and engagement is for detainees at **High imminent** risk of self-harm or suicide. It requires constant line of sight, one-on-one monitoring by the FDSP of, and where appropriate, engagement with, the detainee in a safe environment with a minimum of written observations recorded every 30 minutes by the primary support person (FDSP staff member). The FDSP is to upload written observations in the Department's nominated IT system (CCMD Portal) at the end of each shift. Despite the need for high levels of monitoring, FDSP staff in consultation with DHSP, must continue to consider ways in which contact with	Every 12 hours or as clinically indicated. Secondary assessment by a mental health clinician after 24 hours. **Note:** 12 hourly clinical review to be undertaken by the DHSP as clinically indicated. If the review is due after clinical hours then DHSP to make arrangements for an in person assessment in consultation with the FDSP. The review may be undertaken within 12 hours to accommodate expected sleep/wake cycle. However, this review period

	human support and any other strategies may be used to enhance safety and encourage autonomy. The DHSP must offer the detainee professional psychological support by a mental health clinician. It is not realistic or desirable for the primary support person to constantly 'be with' and interact with a detainee whilst simultaneously recording observations. For high imminent, a secondary support person (FDSP staff member) must provide the primary support person with opportunities for regular breaks. Placement requirements include a safe environment where the detainee can be constantly observed and monitored by the FDSP. While the detainee is free to access areas of the IDF, high imminent level requires FDSP staff to supervise and monitor the detainee's interaction with others. **Note:** Please refer to Detention Services Manual - Detainee placement – Closer supervision and engagement of high-risk detainees (High care accommodation) – PI (DM-626) for further information if high care accommodation is required. **Note:** In situations identified by the DHSP and FDSP where the detainee poses a risk to officers, observational methods of monitoring with suitable adjustments *may* be utilised in some situations, as decided by the FDSP Duty Operations Manager in consultation with the DHSP. Minimally intrusive approaches to wakening may be employed based on clinical advice where waking is required for safety observations. **Note:** Strict time limits apply (24 hours) to the use of constant line of sight monitoring and engagement. For cases that require monitoring beyond the 24 hour time limit, please refer to section 3.5.14 'High Imminent' Risk Level – 24 Hour Limit' in this PI.	should not be extended on a frequent basis and wherever practicable, the 12 hourly review should fall within clinical hours. **Note:** Secondary assessment by a mental health clinician after 24 hours refers to a DHSP mental health clinician. This assessment may occur in person, via tele-health or phone depending on the level of cooperation of the person. For example, if the detainee is uncooperative then an in person assessment is preferable. **Note:** Two clinicians (including one mental health clinician) are required to make a determination to de-escalate a detainee from this risk level, with at least one clinician assessing the detainee in person.
15 minute monitoring (High)	15 minute monitoring and engagement is for detainees at a **high** risk of self-harm. It requires the FDSP primary support person to undertake formally reported monitoring of, and engagement with, the detainee at least once every 15 minutes and at random times (meaning at not precisely the same times such as on the hour or half hour). Monitoring records are to be uploaded by the FDSP in the Department's nominated IT system	Every 24 hours **Note:** 24 hourly clinical review to be undertaken by the DHSP. If the review is due after clinical hours then DHSP to make arrangements for an in person assessment in consultation with the FDSP. The review may be

	(CCMD Portal) at the end of the shift. If the detainee is not immediately available at scheduled observation times, FDSP officers should locate and engage with them as soon as possible after 15 minutes have elapsed. Placement requirements include a safe environment where the detainee can be regularly monitored and observed. While the detainee is free to access areas of the IDF, this level requires FDSP staff to monitor and observe detainee's interaction with others. **Note:** In situations identified by the DHSP and FDSP where the detainee poses a risk to officers, observational methods of monitoring with suitable adjustments *may* be utilised in some situations, as decided by the FDSP Duty Operations Manager in consultation with the DHSP. Skilled minimally intrusive approaches to wakening may be employed based on clinical advice where waking is required for safety observations.	undertaken within 24 hours to accommodate expected sleep/wake cycle. However, this review period should not be extended on a frequent basis and wherever practicable the 24 hourly review should fall within clinical hours. **Note:** Strict time limits apply (24 hours) to the use of constant line of sight monitoring and engagement. For cases that require monitoring beyond the 24 hour time limit, please refer to section 3.5.14 'High Imminent' Risk Level – 24 Hour Limit' in this PI. **Note:** Two clinicians (including one mental health clinician) are required to make a determination to de-escalate a detainee from this risk level, with at least one clinician assessing the detainee in person.
Two hourly monitoring (Moderate (imminent))	A minimum of two hourly monitoring and engagement is required for detainees at a **moderate – imminent** risk of self-harm. While the detainee is free to access areas of the IDF, this level requires FDSP staff to be generally aware of the detainee's circumstances and to record observations on three to six occasions during day shifts hours. Monitoring records are to be uploaded by the FDSP in the Department's nominated IT system (CCMD Portal) at the end of the shift. The focus of this level of monitoring and engagement is to encourage the detainee to integrate into the wider detention community. The support person should ask how the detainee is feeling and encourage a return to normal activities. Examples include getting a friend to visit, going outside, joining others for a meal, listening to music, reading a book. The detainee should also be offered professional psychological support by a DHSP mental health clinician.	Every two days **Note:** Two clinicians (including one mental health clinician) are required to make a determination to de-escalate a detainee from this risk level, with at least one clinician assessing the detainee in person.

	Placement requirements are a normal safe detention environment.	
Once daily monitoring (Moderate (chronic))	Once daily monitoring and engagement is for detainees at a **moderate – chronic** risk of self-harm. This level requires FDSP staff to be generally aware of the detainee's circumstances and to record monitoring observations once during day shifts hours. Monitoring records are to be uploaded by the FDSP in the Department's nominated IT system (CCMD Portal) at the end of the shift. Placement requirements are a normal safe detention environment.	Every five days
Weekly monitoring (Low (Ongoing))	Weekly monitoring is for detainees at a **low** risk of self-harm and do not require an increased engagement or monitoring from the DHSP to manage their risk of self-harm. This level requires FDSP staff to be generally aware of the detainee's circumstances and to record weekly observations as clinically required. Detainees at this level of SME may have a diagnosed mental health condition that may create a risk of self-harm. Detainees must be re-assessed by the DHSP on at least a monthly basis to identify whether there have been any changes in the detainee's mental health or wellbeing that may require a higher level of monitoring. Accommodation requirements are a normal safe detention environment.	Monthly

3.5.12 Risk level and corresponding monitoring requirements

The table above outlines the risk level, the corresponding monitoring and engagement level and the clinical review times required.

SME risk levels do not apply to detainees in RD and in hospital APOD settings. The DHSP must work co-operatively with the FDSP to transport and escort detainees in APODs to hospital and ensure necessary clinical processes and systems are in place. When the detainees are in hospital, health care will be directly provided by the hospital.

If an SRSS Provider or departmental officer (such as a SRO) becomes aware that a detainee in RD has been assessed as being at risk of self-harm or suicide refer to section 9.12 of the SRSS OPM for more information.

3.5.13 Risk level reassessments for detainees on SME

The risk of self-harm must be reassessed by the DHSP as required, based on the circumstances of the individual detainee. The following guidelines are provided to guide and assist in this process.

The need for a reassessment could be triggered by any of the events listed below, but it is important to note that this is not an exhaustive list and other factors or events may warrant a risk reassessment. Some events require an automatic evaluation of risk, whereas others indicate the need to use an informed judgment as to the need for re-evaluation (refer to table below). Any reassessment to de-escalate a detainee from *High Imminent, High, Moderate Imminent* SME risk levels must be made by two clinicians (including one mental health clinician) with at least one clinician assessing the detainee in person. The outcome of any risk reassessment should be discussed with all SME review participants at the daily SME review meeting. Non-clinical SME review participants may comment and provide feedback on the proposed risk reassessment outcome. This discussion and any changes to SME risk levels should be documented on the detainee's mental health care plan, IMP and also, if applicable, behaviour management care plan and scanned onto the detainee's file by the DHSP and emailed to all SME review participants, using approved email addresses.

Need for re-evaluation of risk status of detainees on SME	Presenting factors
Automatic and absolute	• negative visa outcome - primary or appeal • ongoing criminal justice or other legal proceedings • planned removal or return to country of origin following notification to the detainee of a planned removal~~, immediate~~ • other significant set-backs with appeal processes involving the detainee's immigration or visa status • harm (including self-harm) occurring to a friend, family member, or close contact where it becomes known • self-harm or attempted suicide • immediately following discharge from a hospital or mental health unit, due to a mental health condition (including self-harm or through existing PSP processes) • significant medication non-compliance for a consecutive two day period, (particularly for medication required to manage serious mental health conditions such as schizophrenia), especially after recent discharge from hospital or mental health unit stay • unless otherwise triggered, reassessment of self-harm risk will occur during scheduled mental health re-screening as per the mental health screening process (at six, 12 and 18 months, and three monthly thereafter) • a mental health condition has been identified or further identified, during scheduled mental health re-screening or as clinically indicated.

Need for re-evaluation of risk status of detainees on SME	Presenting factors
Judgement required	Including, but not limited to: • changes in sources of support (for example, separation from close family members) and/or significant loss (for example, bereavement) • signs of changes in behaviour • increased aggression • withdrawal or social isolation • signs and symptoms of depression • threats and warning of self-harm • 'contagion' (for example where one incident of self-harm leads to a mass outbreak of self-harming) • Drug and alcohol disorders • past and current traumatic experiences, with or without a diagnosis for PTSD • co-occurring mental illness and substance abuse.

Health risk assessments, under SME, are performed by the DHSP. However, a multi-stakeholder response is particularly important to ensure that an assessment is triggered, if necessary. The presenting factors listed above will not always be apparent. Stakeholders must share information about any possible triggers for individual detainees at SME review meetings. All staff working in the detention environment need to be sensitive to these issues and alert the SME review participants, where necessary.

3.5.14 'High imminent' risk level – 24 hour limit

A detainee who remains at the 'high imminent' risk of self-harm for more than 24 hours must be assessed by a mental health clinician for consideration of their ongoing risk of self-harm. Consideration must be given to whether the detainee should be recommended to the ABF, for transfer to a mental health unit/hospital for further assessment. Any detainee who remains at high imminent risk of self-harm for more than 24 hours must be reassessed, at a minimum, every 24 hours by a mental health clinician. Where practical, there should be a secondary consultation and assessment by a mental health clinician. This assessment may occur in person via tele-health or phone, depending on the level of cooperation of the person. For example, if the detainee is uncooperative then an in person assessment is preferable.

If a detainee has been classified as having a high imminent risk of self-harm level for a continuous 72 hour period, the DHSP must, subject to advice of the psychiatrist or clinical psychologist, transfer the detainee to a mental health unit/hospital (or equivalent) for assessment by that service.

All detainees on high imminent SME for 72 hours or more must also be escalated by the DHSP to the DHSP's Medical Director, Mental Health Services. The ABF IDF SME review participant must also notify the relevant ABF HWO (if applicable) and escalate the case to the ABF Superintendent (Facility) and the Superintendent, Detention Health Operations. In parallel, the DHSP and FDSP must provide ongoing attempts to increase supports and offer strategies for reintegration of the detainee into the wider community.

in the IDF, if the detainee was relocated to alternate accommodation arrangements (for example: High Care or a hospital).

Note: a detainee can (and should) be transferred by the FDSP to a mental health unit or hospital at any point in time, where that is clinically indicated/required by the DHSP.

3.5.15 Step-down from monitoring and engagement

Gradual removal of self-harm prevention responses or transfer between SME risk levels should take place in a considered, and managed fashion, according to reviews discussed by the SME review participants.

To ensure all SME review participants are aware of any detainees who may be suitable to have their risk levels stepped down or ceased from SME at the point of clinical review, the mental health clinician leading the SME review discussions will propose changes at the daily SME review meeting. The SME review participants should discuss any changes, and any disagreement within the SME review meeting must be noted in the minutes of the daily SME meeting and recorded in the detainee's mental health care plan and case file.

Any reassessment to de-escalate a detainee from *High Imminent, High, Moderate Imminent* SME risk levels must be made by two clinicians (including one mental health clinician), with at least one clinician assessing the detainee in person. If a review of SME risk levels of a *High Imminent, High, Moderate Imminent* risk case is required or it is proposed to reduce the level of monitoring during after clinical hours or during the weekend, the DHSP mental health nurse on the HAS line must engage with the FDSP or ABF duty officers to make arrangements for an in person assessment. The SME review participants should review and discuss this changed risk level again, at the next available SME review meeting.

The DHSP SME review leader (mental health clinician) should also facilitate discussions regarding the placement of the detainee. These discussions should canvass any accommodation recommendations directly relevant to the safety of the detainee and also the allocation of responsibilities for all key SME review participants. If it is decided that a detainee's SME risk level is to be downgraded or that SME will cease, the DHSP is to provide, in writing, the SME plan to all SME review participants so they are aware of any required actions that are allocated to them. The DHSP should then scan a copy of the SME plan, into the detainee's medical records.

3.5.16 Escalation of complex cases and issues

'Complex needs' is a term used to describe the compounding difficulties and problems experienced by individuals with two or more mental disorders, or any combination of mental disorder, cognitive impairment and/or problematic drug and/or alcohol use.

There may be times when the SME review participants or local ABF officers are unable to effectively manage a case in accordance with the guidelines outlined above. This may be because:

- the group encounters barriers to accessing care from the public health system.
- the detainee refuses medical treatment.
- it is clinically not appropriate or effective for a detainee to be managed on SME due to specific issues that are outside the purpose of the PSP (such as complex needs and challenging behaviour).
- it is not clinically appropriate or effective for the detainee to continue to be managed on SME, due to the time the detainee has remained on a moderate to high level of SME.

In these circumstances, the case must be immediately escalated for resolution to the ABF Superintendent (Facility) and the Superintendent, Detention Health Operations.

Where a detainee with mental capacity refuses medical treatment, the DHSP will record the refusal on the detainee's health care record. If the detainee refuses to be transferred to hospital for treatment then the

DHSP will continue to instruct SME review participants on the management of that individual case. For guidance refer to: Detention Health: Universal Privacy, Consent and Medical Records - PS (DM-6317).

3.5.17 Post-incident/postvention response

Post-incident responses, and the implementation of postvention measures, where a detainee died by suicide or attempted serious self-harm, are critical to prevent harm extending to other detainees. People bereaved by suicide are at an increased risk of suicide and self-harm, particularly those with existing vulnerabilities. Such individuals are also at greater risk of developing adverse mental health reactions, including prolonged grief disorders and complications to and exacerbation of existing mental health conditions. In addition, failure to actively respond to self-harm incidents may increase the risk of self-harming or other protest behaviours by other detainees.

The following table describes the five stage process that must be followed in the event of an incident of serious self-harm.

Item	Stage	Who	Description
1	Pre-requisite - Awareness.	FDSP, DHSP, ABF, the Department and external trainers	• Staff to be made aware that self-harming activities can cause distress to others in detention (known as the 'contagion' effect). • Suicide bereavement and postvention strategies must be included in mandatory training on self-harm and suicide.
2	Immediate response - Communication.	FDSP and DHSP (particularly the mental health team)	• Reassure anyone who witnessed or was involved in the incident, that medical care/hospitalisation has been provided (as relevant) and the detainee is receiving treatment. • Communication should continue for as long as the mental health team considers necessary.

Item	Stage	Who	Description
3	Post-incident response- Debrief with individuals, offer support as part of bereavement or postvention strategy.	DHSP (particularly mental health team)	• Ask all staff to identify detainees who they think might be particularly affected, such as those who may have witnessed or been involved in the incident, or who may know the detainee. • The mental health team should debrief with these detainees. The aims are to: - identify persons who are distressed - offer support, including connection with relevant mental health services - help detainees see that self-harming is not a constructive course of action - identify any triggers or contributing factors - provide advice, guidance and support in implementing coping strategies for detainees. **Note:** All departmental officers should encourage their staff or colleagues to access Employee Assistance Program (EAP) services after a serious incident of self-harm. Contracted service provider staff should be encouraged to access their relevant staff support services.
4	Post-incident response - Debrief with general detainee population, offer support as part of bereavement and postvention strategies.	DHSP – onsite mental health team and FDSP	• Debrief with the wider detainee community to give accurate information, prevent gossip and offer support. • The need for this type of debriefing should be determined with regard to the severity of the incident and the likely awareness of the incident within the IDF.
5	Post-incident response - Report systemic issues to centre management.	ABF, FDSP, DHSP and the Department	• Any triggers or contributing factors identified through debriefing should be reported to centre management through incident reports and team meetings. • Identified triggers should be actively reviewed and, where possible, addressed as part of quality improvement processes.

Note: the SME clinical team leader determines which self-harm incidents are serious enough to warrant a post-incident response.

For more information on processes to follow regarding post-incident resolution reporting, refer to Detention Services Manual - Safety and security management – Incident management and reporting – PI (DM-616) .

For guidance on debriefing staff after an incident, refer to Detention Services Manual – Safety and security management – Debriefing – SOP (DM-3304).

Please note the disclosure of a detainee's personal information must be in accordance with the *Privacy Act 1988*. Some detainees and staff may be aware of the identity of the person who has self-harmed or committed suicide, whereas others will not be aware, and discussions should be tailored appropriately to protect confidentiality where necessary.

For more information on privacy and disclosure, refer to Detention Health: Privacy, Consent and Medical Records – PI (DM-5925).

3.5.18 Supportive monitoring and engagement in the absence of a mental health clinician

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

When self-harm or suicide concerns arise, in the absence of a mental health clinician, FDSP (and nominated ABF officers, if appropriate) should immediately commence Keep SAFE and notify the DHSP as soon as reasonably practicable. Please refer to Detention Health: Responding to Self-Harm – SOP (DM-3283) for further information on Keep SAFE. It is also acknowledged that the facility service provider may also have an equivalent policy in use. If outside clinical hours the FDSP should utilise the HAS line until the mental health clinician is available onsite.

If a clinician is not available to make an assessment of the level of self-harm risk, the following process is to be implemented.

Stage	Action
1	Departmental or FDSP staff who become aware of self-harm or suicide concerns about a detainee at a time when the DHSP mental health clinicians are not available to make an assessment of the detainee's level of risk under the PSP: • The first officer on the scene (usually the FDSP) will immediately engage FOM or Shift Supervisor who will commence Keep SAFE with the detainee until such time as a mental health clinician is available to make an assessment of the detainee's level of risk under this policy • Where there are also serious concerns about the detainee's physical condition (for example chest pains or difficulty breathing), the FDSP should ensure an ambulance is called immediately. If after clinical hours and there are other, less immediate concerns about the physical health of the detainee, the FDSP should call the DHSP HAS line for advice as to whether an in person assessment is required and/or for advice as to treatment for physical and mental health concerns • FDSP staff will contact FDSP FOM and ABF Duty Officer, as soon as reasonably practicable and in line with local PSP and incident reporting procedures.
2	• Departmental shift manager and/or ABF duty officer and the FDSP FOM and/or FDSP officers should escalate the issue as required, in consultation with the HAS line, including non-mental health clinicians if relevant (for example, GP, paramedic, nurse). • A decision should be made by the departmental shift manager and/or ABF duty officer, and the FDSP FOM as to whether the detainee can be safely accommodated onsite.

3	• Keep SAFE will continue while advice is sought from the FDSP FOM and departmental shift manager and/or ABF duty officer.
4	• If not already arranged at stage one, the DHSP (if outside clinical hours via the HAS line) should be notified as soon as possible to arrange for a timely in person assessment by a mental health clinician for high risk cases, or via telehealth for low risk cases.
5	Once a preliminary assessment has been made by the FDSP and departmental shift manager and/or ABF duty officer, in consultation with the DHSP mental health clinician (through the HAS line), the following should be undertaken: • safe and secure placement and Keep SAFE response for the detainee, the FDSP will continue with Keep SAFE until a DHSP mental health clinician is available on-site to conduct an assessment • consideration of the need for an immediate assessment of the detainee by a mental health clinician or the need to transfer the detainee to a hospital or a mental health facility • consideration of whether the FDSP is required to arrange for immediate transport to hospital or equivalent setting for a clinical assessment where required • as soon as a mental health clinician is available to assess the detainee, FDSP and ABF duty staff are to fully brief the clinician and act in accordance with the clinician's assessment of the detainee's level of risk.

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

Note: SME plans can only be implemented after a detainee's SME risk level has been determined following an assessment by a DHSP mental health clinician. ABF, SROs, and FDSP staff are not able to make these determinations about SME risk level and response without expert clinical advice. Should a detainee who is already on a SME plan require an escalation (from a self-harm threat for example), then the previous conditions of that plan are to be replaced by the immediate Keep SAFE response requirements. This is to remain in place until further advice is provided from the DHSP, noting this advice should be obtained as soon as practicable and in writing to all SME review participants via approved email addresses. Refer to section 3.5.9 Self-harm Risk Levels of this PI for further information and guidance outside clinical hours.

Keep SAFE is to cease once:

- an updated SME plan is developed and recorded by the DHSP in the detainee's mental health record and confirmed in writing to all respective SME review participants via approved email addresses
- the DHSP confirm in writing to all respective SME review participants via approved email addresses and record in the detainee's mental health record that no SME plan update is required, and the existing plan can be re-instated, or
- transfer of this aspect of care management is carried through to a hospital or equivalent setting.

3.5.19 Supportive monitoring and engagement responses without a mental health clinician

Where Keep SAFE has been implemented, ABF and FDSP officers should utilise the following methods of monitoring and engagement:

- maximise opportunities for personal contact, interaction and conversations, and should not rely on visual contact through Closed-Circuit Television (CCTV) or windows

- not isolating the detainee from others, including staff, by placement in an area without human contact unless the detainee is a severe threat to themselves or others
- allowing the detainee to express their distress or anger
- moving the detainee to an area within their place of immigration detention that will allow the above to occur (caution should be taken in relation to moving a detainee from their usual accommodation).

3.5.20 Determining whether a detainee should be transferred to a hospital

If the environment does not enable SME to occur or emergency care is required, then the detainee should be considered (by the DHSP or HAS line outside clinical hours) for transfer to a hospital or other suitable health care facility for assessment and placement, noting that a detainee should consent to the transfer.

Similarly, if a DHSP clinician recommends a transfer to hospital, this should occur. If the detainee does not consent to a transfer, the DHSP (assisted by the FDSP as necessary) should counsel the detainee about the importance of seeking treatment and agreeing to the transfer. If the detainee cannot be persuaded, the DHSP must consider what further steps are required, including referring the detainee for assessment for a potential treatment order if appropriate. Refer to section 3.7 Treatment Orders in immigration detention in this PI.

3.5.21 Recording supportive monitoring and engagement decisions

A detainee Keep SAFE decision is made by the FDSP and a PSP process decision is made jointly amongst all stakeholders, but under direction from a mental health clinician. This is an important distinction to make in FDSP records.

When recording a decision to begin Keep SAFE on the Department's CCMD portal, including in Incident Reports, FDSP staff should include a free-text note advising that the decision was made *without* the detainee being assessed by a mental health clinician at the time.

The FDSP and DHSP are to ensure in their advice and reporting regarding Keep SAFE and SME that the distinction between these processes is clear.

3.5.22 Self-harm prevention in residence determination

The DHSP has responsibility for managing and organising the delivery of health care to detainees who are covered by a RD, through a multidisciplinary team of health care providers. Mental health services for detainees who are covered by a RD are coordinated by the DHSP. The detainee should be transferred to a hospital if the self-harm or suicide risk is imminent. If it becomes known to a SRSS Provider or departmental officer that a detainee who is covered by a RD has been assessed as being at risk of self-harm or suicide, then refer to section 9.12 of the SRSS OPM for more information.

The Department has engaged a number of service providers, through the SRSS program, to provide care and welfare support to detainees who are covered by a RD. SROs also have an important role in ensuring that reasonable measures are in place to ensure the wellbeing of detainees who are covered by a RD, while their immigration status is being resolved.

3.6 Minors in an IDF

3.6.1 Child Safeguarding

The Child Safeguarding Framework (the Framework) articulates the strong commitment of the Department, including the ABF, to safeguarding children and their wellbeing, and supports the implementation of Australia's international obligations under the United Nations Convention on the Rights of the Child in a domestic operational environment. The Framework and the Department's child safeguarding policies apply

to all departmental staff, ABF officers and contracted service providers involved in the care and support of children and their families in Australia's immigration programs.

This PI complies with the Department's requirement to act consistently with Australia's international and domestic legal obligations in relation to providing a safe environment for children and their families while complying with existing legislative and policy parameters.

For further information on the Department's Child Safeguarding Framework, please refer to the Child Safeguarding Framework – Policy Statement (BE-916).

3.6.2 Reporting requirements for mandatory reporters

Mandatory reporters are required by law to report suspected child abuse and neglect to government authorities. In Australia, each state and territory government has enacted mandatory reporting laws to impose a legislative requirement on selected classes of people to report suspected cases of child abuse and neglect. Though the mandatory reporting laws differ across jurisdictions (in relation to terminology, scope and timeframes of a report), health professionals are consistently listed by each jurisdiction as mandatory reporters.

Irrespective of state and territory reporting laws, the expectation is that all Immigration and Border Protection (IBP) workers (including contracted service providers) will report child protection concerns. The requirement for IBP workers to report any child protection concerns is in accordance with the Reporting Child-related Incidents - PI (DM-5858) and in addition to a person's obligations imposed by state/territory legislation to report child protection incidents.

3.6.3 Application of the mental health policy to minors

The complexities in identifying psychological distress in minors should be kept in mind, being aware of factors that may prevent symptoms from being reported, including that minors may not have the skills to report distress symptoms. The DHSP and FDSP should take seriously and investigate reports of mental health concerns from parents, other adult family members and other persons in regular contact with a minor.

The DHSP and FDSP should be mindful that parents and caregivers may not have the knowledge and skills to effectively communicate concerns, or the necessary understanding of the practices and options available, in detention. This also includes awareness of cultural perspectives that may inhibit help-seeking behaviours. To enable them to make decisions for minors in their charge, parents and caregivers should be provided with information about the services available and how they can be accessed.

For advice relating to supporting the wellbeing, safety and security of minors in immigration detention, refer to Best practice for interacting with Children − PI (BC-764) or contact Child Wellbeing Operations via email at childwellbeingoperations@homeaffairs.gov.au.

Parents and caregivers may also have mental health issues and may not be able to provide the necessary support to minors in their charge, including the capacity to make informed decisions about their own health care or that of the minors in their charge. For further information regarding decision making and the application of mental health policy to minors, please refer to Detention Health: Health Screening of Minors - SOP (DM-3278).

The DHSP must ensure that minors and their parents and/or caregivers who may require individual and/or family counselling sessions are identified and provided with or referred to counselling, as well as offered or referred to other forms of support, including:

- general health awareness and education programs that are culturally appropriate
- peer education programs that discuss parenting skills and improved parent-child interactions

- for UAMs, care should be taken to consider a range of different means of addressing their needs, including the use of individual counselling, as well as group counselling for those with common experiences or strongly developed bonds.

3.6.4 Special considerations regarding minors in immigration detention

Special measures should be undertaken to promote and manage the mental health of minors in immigration detention.

The means by which a supportive environment will be provided by the Department and its service providers (the DHSP and FDSP) may include health promotion and prevention initiatives such as:

- access to recreational facilities (outdoor where possible) and meaningful activities
- access to educational facilities
- opportunities to build community and increase social interaction with peers, where possible, within places of immigration detention
- engagement with community groups.

If a minor is involved in a self-harm and/or suicide incident, either as the person at risk, or as a member of a family unit or social group of a person at risk, DHSP clinicians with expertise in child and adolescent mental health must be included in the SME review meetings. If a minor is involved in a self-harm and/or suicide incident, the minor detainee's CIMP, IMP and/or mental health care and SME plans must be updated as appropriate. The ABF duty officer must notify Child Wellbeing Operations via email childwellbeingoperations@homeaffairs.gov.au.

3.6.5 Parent or guardian consent

It is essential to note that all health and mental health assessments of minors require informed consent from the minor (if able to do so), a parent or guardian, or authorised delegate under the *Immigration (Guardianship of Children Act) 1946*. The exception to this is when the health/medical issue is related to alleged or actual violence, abuse or neglect perpetrated by the parent or guardian. For more information refer to section 3.2.3 Detention Health: Privacy, Consent & Health records − PI (DM-5929)**.**

There may be circumstance in which a minor may be able to provide consent to some medical assessments, procedures and/or treatments on their own behalf, depending on their age, and capacity to understand the nature of the health or mental health assessment and the consequences, if any, of their participation. A child who is able to provide informed consent to medical assessments, procedures and/or treatments is known as 'Gillick Competent', Gillick Competence should be assessed by a medical professional and/or a court (depending on the assessment, procedure and/or treatment). For more information on consent by minors, refer to Detention Health: Privacy, Consent and Medical Records − PI (DM-5925).

3.6.6 Immigration (Guardianship of Children) Act 1946 (IGOC Act)

The IGOC Act provides that the Minister (the Minister) for Immigration, Citizenship, Migrant Services and Multicultural Affairs is the guardian of certain non-citizen children, known as IGOC minors. In accordance with section 5 of the IGOC Act, the Minister may delegate his powers and functions to an officer or authority of the Commonwealth or any State or Territory under the *Immigration (Guardianship of Children) Delegation Instrument 2019 (19/086)*. For IGOC minors in IDFs and RD, the Minister has delegated ministerial powers and functions to certain departmental officers, known as the 'IGOC delegate'.

The Minister may place an IGOC minor in the custody of a person or organisation under section 7 of the IGOC Act. Where an IGOC minor is residing at a place in accordance with a RD, the minor is usually placed in the custody of the contracted SRSS provider. The custodian can provide consent for routine or minor medical issues. For more information on the role of the custodian please see the *Immigration (Guardianship of Children) Regulations 2001.* For non-routine medical issues, or other issues which require the guardian's

consent, departmental officers, such as the departmental SRO can facilitate the appropriate approval from the IGOC delegate.

For more information and support in relation to IGOC minors, refer to Unaccompanied Humanitarian Minors and Guardianship section at uhm.operations@homeaffairs.gov.au.

3.6.7 Risk factors

Risk factors for mental health issues affecting minors in immigration detention may include:

- exposure to traumatic events
- primary care-giver distress and/or exposure to trauma
- living in uncertain and restrictive environments
- separation from parents/primary carers/siblings.

3.6.8 Exposure to traumatic events

Minors in immigration detention may have experienced trauma prior to and/or after their arrival in Australia. Exposure to traumatic events can impact on a minor's brain development and function.

3.6.9 Primary caregiver distress and/or exposure to trauma

The mental health of parents and primary caregivers has an impact on the mental health of dependent minors. The good mental health of parents and other primary caregivers can help to minimise the negative impacts that exposure to traumatic events have on minors.

Parents and primary caregivers who are traumatised and distressed are unlikely to be able to meet the emotional needs of dependent minors and may struggle to provide effective stable parenting. Without effective parenting, there is an increased risk that these minors will develop mental health issues themselves.

3.6.10 Living in uncertain and restrictive environments

The environment in which people live can impact on their mental health and on their ability to manage traumatic experiences. Uncertainty about the future is an experience common to detainees in immigration detention and has been identified as a key health risk factor, as uncertainty can exacerbate mental health issues in both adults and minors.

When uncertainty is coupled with restrictive living conditions, such as those experienced in IDFs, there can be a negative impact on the ability of a family to function as an autonomous unit. Generally, while minors are not detained in IDCs, the level of control and limitation in an APOD is greater than that of those in the Australian community. These restrictions may limit the family's autonomy and can undermine its structure.

Placement decisions rely on a thorough assessment of the identified risks associated with a detainee. Minors, where possible, should be located with parents/guardians or know where the parents/guardians are, and have regular access to them.

For guidance, refer to the:

- Detention Services Manual - Detainee Placement - Assessment and placement of detainees in IDFs - PI (DM-5126)
- Detention Services Manual - Detainee placement - Detainee placement - SOP (DM-3248)
- Detention Placement Assessment Functional Guide (ADD2020/5111007).

For more information on placements, contact Detention Management and Planning Section via email: nationaldetentionplacements@abf.gov.au.

3.6.11 Identification of psychological distress and signs of torture and trauma in minors

Identifying psychological distress in minors can be complex. Minors do not necessarily have the skills to report symptoms of psychological distress. For example, they may be unable to verbalise their feelings or report their experiences.

The DHSP and FDSP must be mindful of the signs of psychological distress that may be related to torture and trauma in minors and where possible, early intervention measures are put in place to support minors with mental health issues.

Signs of psychological distress that may be related to torture and trauma in minors may include:

- loss of appetite
- anxiety
- hostility and oppositional behaviour
- sleep disorders
- self-destructive and self-harming behaviours
- emotional disturbances including depression and unresponsiveness.

Other signs of psychological distress are more specific to minors, such as:

- learning and developmental difficulties
- physical symptoms such as stomach aches and headaches
- bed-wetting and other loss of bodily control
- refusal to eat or drink or obsession with food
- regression to earlier developmental stages.

3.7 Treatment Orders in immigration detention

A Treatment Order is an order enabling a detainee to be given treatment for mental illness, in some situations in the absence of the detainee's informed consent. Such orders enable a substitute decision making framework specific to treatment of mental disorder for detainees with mental illness who, because of their illness, cannot make their own treatment decisions but who need treatment for their own health or safety, or to ensure the safety of others. A Treatment Order sets out the terms under which a detainee must accept inpatient or community mental health care, medication and attendance with follow-up services. Treatment Orders relate to mental health treatment only and are not relevant to physical health care or lifestyle.

Treatment Orders are provided by each Australian state and territory's mental health legislation and there are some variations in the administration of Treatment Orders and their terminology and provisions, depending on jurisdiction.

It is expected that the DHSP and FDSP will work cooperatively with health authorities to implement a Treatment Order issued under state or territory legislation for a detainee. There are provisions in the *Migration Act 1958 (the Act)* and the *Migration Regulations 1994* (the Regulations) which afford flexibility as to the care people receive when they are in detention. This means that there is considerable latitude for

departmental officers to administer the Act in such a way as to avoid inconsistency with state or territory law, including in relation to Treatment Orders. If there is any concern about the terms of a Treatment Order (for example, if it appears to be inconsistent with the need to keep a detainee in immigration detention), contact Detention Health Policy and Assurance at health@homeaffairs.gov.au for assistance or the Legal Opinions Helpdesk at lohd@homeaffairs.gov.au for legal advice.

A Treatment Order may:

- require a detainee to be given specified treatment
- require a detainee to be treated at a particular place
- require a detainee who is being treated to be admitted to hospital or a mental health facility, to allow treatment
- specify other requirements.

The DHSP should follow the relevant state or territory legislation regarding Treatment Orders. The table below, which is not intended as a comprehensive summary, outlines the provisions under relevant State or Territory mental health legislation and provides an overview of certain relevant provisions regarding available Treatment Orders in each State or Territory. Each State and Territory has a different scheme. In each situation, it is important to check the scheme itself, as well as the relevant order.

For any Treatment Order made in relation to a particular detainee, the exact terms of the Treatment Order should be carefully considered. For further information regarding the specific legislation in each state and territory with regard to mental health Treatment Orders, refer to section 3.7.1 of this PI.

3.7.1 State and Territory Treatment Order Legislation[11]

ACT

Mental Health Act 2015

State / Territory	Mental Health Legislation	Treatment Orders		Duration of order (unless otherwise specified)	Additional information
Australian Capital Territory	*Mental Health Act 2015*	Mental Health Orders.	Assessment Order (s.37).	The assessment of a person in relation to whom an assessment order is made must be conducted as soon as practicable, and not later than: seven days after the day the order is made, or unless an earlier day is stated, or if a removal order is made under s.43(2), seven days after the day the removal order is executed (s.42). **Note:** the ACAT may, on application, extend the period of	Issued by the ACT Civil and Administrative Tribunal (ACAT) following a hearing.

[11] Please note that these links are current, as of 3 July 2023.

				the assessment by up to seven days if it is satisfied, based on clinical evidence that a satisfactory assessment cannot occur within the initial seven day period.	
			Emergency Assessment Order (s.39).	As quickly as possible, but no longer than seven days after the day the order is made.	May be made where the ACAT is considering a s.37 assessment order or the president of the ACAT has a serious concern for the immediate safety of the person, or another person related to the assessment order application.
			Psychiatric Treatment Order (s.58).	six months (s.76)	
			Community Care Order	six months (a restriction order can only be applied for a period of three months)	
			Emergency Detention (chapter 6).	No more than three days (s.85(1)) where the doctor has reasonable grounds for believing that: the person requires immediate treatment, care or support, and the person has refused to receive the treatment, care or support, and detention is necessary for the person's health and safety, or the protection of another person, and	

				adequate treatment, care or support cannot be provided in a less restrictive environment. **Note:** this period may be extended through making an application to the ACAT for no longer than 11 days.	

NSW

Mental Health Act 2007

State / Territory	Mental Health Legislation	Treatment Orders		Duration of order (unless otherwise specified)	Additional information
New South Wales	*Mental Health Act 2007*	Involuntary Treatment Orders.	Involuntary Admission (Division 2).	12 hours before first examination by an authorised medical practitioner. A second medical practitioner then reviews the person as soon as reasonably practicable. Where the first and second medical practitioners disagree, a third medical practitioner is required to examine the person as soon as possible. If at least two of the medical practitioners agree that the person is mentally ill, they must be brought before the Mental Health Tribunal as soon as reasonably practicable for review. (s.27) A person who is found to be mentally disordered is only to be detained for a maximum continuous period of three days.	A person may be detained in a mental health facility where: A medical practitioner has issued a certificate (after examination) setting out the person is mentally ill or mentally disordered and there are no other appropriate means for dealing with the person; or An ambulance officer who provides ambulance services to a person has reasonable grounds to believe that the person appears to be mentally ill or mentally disturbed and that it would be beneficial to the person's welfare to be dealt with in accordance with the Act; Where a magistrate or authorised officer is satisfied that the person is mentally ill or mentally disordered and there are no other appropriate means for dealing with the person. **Note:** a person will be released as soon as reasonably practicable where the medical practitioner has found them not to be mentally disordered or mentally ill.

				Note: a person found to be mentally disordered cannot be detained on this basis on more than three occasions in any one calendar month.	
			Mental Health Inquiry (Division 3).	May extend detention under a Division 2 admission by up to 14 days (s.35(4)).	
			Community Treatment Orders (s.51).	No longer than 12 months (s.53(6)).	Issued by the Mental Health Review Tribunal. An order that the person be detained in or admitted to and detained in a specified mental health facility, should only be made if the Tribunal is of the opinion that no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available or that for any other reason it is not appropriate to make any other order. May be remade on application to the Mental Health Tribunal.
			Involuntary Patient Order (s.35(5)(c)).	Three months (s.35(5)(c)).	

QLD

Mental Health Act 2016

State / Territory	**Mental Health Legislation**	**Treatment Orders**		**Duration of order (unless otherwise specified)**	**Additional information**
Queensland	*Mental Health Act 2016*	Involuntary Orders.	Inpatient Category.	Until criteria no longer met.	Should be no less restrictive way for the person to receive treatment and care for their mental illness. Issued by an authorised doctor, who is to review every three months.

			Community Category.		Reviewed at regular intervals by the Mental Health Review Tribunal.

NT

Mental Health and Related Services Act 1998

State / Territory	Mental Health Legislation	Treatment Orders		Duration of order (unless otherwise specified)	Additional information
Northern Territory	*Mental Health and Related Services Act 1998*	Involuntary Treatment.	Admission Order (s.39).	For up to 24 hours, or up to 14 days where an authorised psychiatric practitioner makes the recommendation for psychiatric examination of the person before the admission (s.39(1)). This may be extended a further 14 days where an authorised medical practitioner considers that it is necessary. On review by the Mental Health Tribunal, may be extended for an additional three months where the Tribunal is satisfied that the person should be admitted on the grounds of mental illness.	An authorised psychiatric practitioner must examine an involuntary patient detained on the grounds of mental illness no less than every 72 hours. **Note:** A person is required to be released following review should they be found to no longer be mentally ill.
			Involuntary Admission on the Grounds of Mental Disturbance (s.41(1)).	Up to 72 hours. This may be extended by up to 7 days if, after examination, two authorised psychiatric practitioners are satisfied (s.42(2)) that: a) If the person is released they are likely to cause serious harm to themselves or others/will represent a substantial danger to the general community/are likely to	An authorised psychiatric practitioner must examine a person admitted as an involuntary patient on the grounds of mental disturbance: a) not less than once every 24 hours, if the person is detained under section 42(1); or b) not less than once every 72 hours, if the person is detained under section 42(2) or 123(5)(b).

				suffer serious mental or physical deterioration; b) That the person is not capable of giving informed consent or has unreasonably refused to consent to treatment; and c) There is not a less restrictive way of ensuring that the person receives the treatment or care. On review by the Mental Health Tribunal, may be extended for an additional 14 Days.	**Note:** A person is required to be released following review should they be found to no longer be mentally disturbed.
			Involuntary admission on grounds of complex cognitive impairment (div.4) not longer than 14 days (s.44F).	If an application for such an order is made and the person is already admitted on the grounds of mental disturbance, it must be made before the Tribunal is required to review the admission (24, or 72 hours) (s.44F). On review by the Mental Health Tribunal, may be extended for an additional 14 days (s.123(5)(ba)).	Once admitted, the person must be examined every 72 hours. **Note:** A person is required to be released following review should they be found to no longer fit the grounds for involuntary admission under this section
			Interim Community Management Order (s.45).	An interim community management order remains in force for 14 days.	
			Community Management Order (s.48).	Imposed by the Mental Health Tribunal after reviewing an interim community management order, may be imposed for six months.	Must be reviewed every 14 days. **Note:** A person is required to be released following review should they be found to no longer fit the grounds for involuntary admission under this section

SA

Mental Health Act 2009

State / Territory	Mental Health Legislation	Treatment Orders	Duration of order (unless otherwise specified)	Additional information
South Australia	*Mental Health Act 2009*	Community Treatment Orders (s.10).	Level 1 Community Treatment Order – no later than 42 days after the day on which it is made (s.10(4)) .	Can only be made when: • the person has a mental illness • the person requires treatment for their, or another's, protection • the person is unable to make informed consent regarding treatment, and • there are no less restrictive ways of ensuring that a person gets appropriate treatment. **Note:** May be revoked at any time following examination by an authorised medical practitioner **(s.10(7))**
			Level 2 Community Treatment Order – (a) in the case of an order relating to a child—no later than six calendar months after the day on which it is made (s.16(5)(a)); or (b) in any other case—no later than 12 calendar months after the day on which it is made (s.16(5(b)).	Can only be made when: • the person has a mental illness • the person requires treatment for their, or another's, protection • the person is unable to make informed consent regarding treatment, and • there are no less restrictive ways of ensuring that a person gets appropriate treatment. **Note:** May be revoked at any time following an application to the Tribunal **(s.16(7))**

		Inpatient Treatment Orders.	Level 1 Inpatient Treatment Order – no later than 7 days after the day on which it is made (s.21(4)).	Can only be made when: • the person has a mental illness • the person requires treatment for their, or another's, protection • the person is unable to make informed consent regarding treatment, and • there are no less restrictive ways of ensuring that a person gets appropriate treatment. **Note:** May be revoked at any time following examination by an authorised medical practitioner **(s.21(7))**
			Level Inpatient treatment order - 42 days (s.25(6)). This may be extended by an additional 42 days following an examination by an authorised medical practitioner (s.25(7)).	Can only be made when: • the person has a mental illness • the person requires treatment for their, or another's, protection • the person is unable to make informed consent regarding treatment, and • there are no less restrictive ways of ensuring that a person gets appropriate treatment. **Note:** May be revoked at any time following examination by an authorised medical practitioner **(s.25(8))**.
			Level 3 Inpatient Treatment Order – (a) in the case of an order relating to a child —six calendar months, or (b) in any other case —12 calendar months.	Can only be made when: • the person has a mental illness • the person requires treatment for their, or another's protection • the person is unable to make informed consent regarding treatment, and • there are no less restrictive ways of ensuring that a person gets appropriate treatment. **Note:** May be revoked at any time following examination by an authorised medical practitioner **(s.25(8))**.

TAS

Mental Health Act 2013

State / Territory	Mental Health Legislation	Treatment Orders	Duration of order (unless otherwise specified)	Additional information
Tasmania	*Mental Health Act 2013*	Assessment Orders (Part 3 Division 1).	24 hours (s.24). May be extended to a period by up to 72 hours (s.32(7)).	
		Interim Treatment Orders (s.38).	10 days (s.38(9)).	Interim Treatment Orders are made without a hearing by a single tribunal member.
		Treatment Orders.	Six months (s.44). May be renewed through application to the Tribunal for (s.48(8)): • A period not exceeding 6 months if it has not previously been renewed; or • In any other case, a period not exceeding 12 months.	Treatment Orders are made by the Mental Health Tribunal after a hearing before at least three tribunal members.

VIC

Mental Health Act 2014

State / Territory	Mental Health Legislation	Treatment Orders		Duration of order (unless otherwise specified)	Additional information
Victoria	*Mental Health Act 2014*	Assessment Orders.	Community Assessment Order (s.34).	24 hours (s.34(1)(a)) May be extended by 24 hours no more than two times (s. 34(3))	Practitioner should be satisfied that there is no less restrictive means

			Inpatient Assessment Order (s.34).	24 hours (s.34(1)(b)(i)) if the person is received at a designated mental health service or 72 hours (s.34(1)(b)(ii) if the person is not received at a designated mental health service. May be extended by 24 hours no more than two times (s. 34(3)).	reasonably available to assess or treat the person. One of the objectives of the Act is 'to provide for persons to receive assessment and treatment in the least restrictive way possible with the least possible restrictions on human rights and human dignity.' Treatment Orders are made by the Mental Health Tribunal following a hearing. Section 67 states that a Treatment Order will have **no effect** while a person is in immigration detention unless the person is assessed or receives treatment as an inpatient.
			Community Court Assessment Order (s.39).	Seven days.	
			Inpatient Court Assessment Order (s.39).	Seven days.	
		Temporary Treatment Order (s.58).		28 days May be extended by no more than 10 days by the Tribunal, should an adjournment be required (s.192).	
		Treatment Orders (s.52).	Inpatient Treatment Orders.	Six months (s.57(2)(a)(ii)) May be extended by no more than 10 days by the Tribunal, should an adjournment be required (s.192).	
			Community Treatment Orders	12 months(s.57(2)(a)(i)) May be extended by no more than 10 days by the Tribunal, should an adjournment be required (s.192).	
			All Treatment Orders for	Three months(s.57(2)(b)) May be extended by no more than 10 days by	

			those under 18 years.	the Tribunal, should an adjournment be required (s.192).	
			Community Treatment Order (s.23).	Until criteria no longer met.	

WA

Mental Health Act 2014

State / Territory	Mental Health Legislation	Treatment Orders		Duration of order (unless otherwise specified)	Additional information
Western Australia	*Mental Health Act 2014*	Examination.		No longer than 24 hours.	
		Involuntary Treatment Order.	Inpatient Treatment Order (s.22).	Until criteria no longer met.	Issued by a treating psychiatrist. Must be reviewed by the Mental Health Tribunal within 35 days, or 10 days for children. Criteria includes that the patient cannot be provided with adequate treatment in a way that would involve less restriction on their freedom of movement and choice.

3.8 Coordination and continuity of care

The DHSP must provide coordinated care for detainees and maintain comprehensive detainee health records that promote coordination of care, among multiple practitioners.

The continuity of care requirements and the associated records for detainees with mental health issues being transferred between IDFs or being released into the community, are outlined in the Detention Health: Placements and Transfers − PI (DM-5927) and Detention Health: Health Discharge Assessment − PI (DM-5261).

Both the DHSP and FDSP are responsible for providing comprehensive handovers at changes of shift to ensure continuity of care for detainees in an IDF. Incoming staff must be fully briefed by the outgoing DHSP and FDSP staff, and must continue to follow all SME plans. It is the responsibility of the FDSP FOM to ensure that plans are adhered to.

3.8.1 Transfer within the immigration detention network

The DHSP must ensure that any information, clinical records, and notes are updated at each contact with the detainee, at the conclusion of each medical appointment.

If a detainee is being transferred within the IDN, the DHSP is responsible for ensuring continuity of care – including the provision of services, medical appointments and referrals (as required). Any concerns regarding mental health and the ability to travel, should be mentioned in the detainee's fitness to travel assessment (FTTA).

Particular attention should be given to detainees who are currently receiving treatment or services for mental health conditions, to ensure they are linked in with appropriate services upon arrival at the receiving IDF, to ensure appropriate and continued support is provided.

3.8.2 Transition into the community on a bridging or substantive visa

For those individuals who are transitioning into the community from either an IDF or RD, the DHSP must ensure that the HDS and appropriate information and assistance in how to link with relevant medical services in the community, is provided to the detainee to facilitate continuity of care. The HDS should clearly outline the detainee's required support needs, including any medical and/or clinical services and medication.

If the detainee is transitioning into the community through the SRSS program, the SRO and SRSS Provider should assist in linking the detainee to appropriate services and support in the community.

3.8.3 Removal from Australia

The DHSP must consider the detainee's medical and/or clinical needs as part of planning for a removal and will liaise with the ABF to ensure that appropriate support arrangements are in place.

For those individuals being removed from Australia, a FTTA will be conducted. The FTTA must take into account the physical and mental health of the detainee and whether additional clinical or mental health support is required during travel. If a detainee has a known mental health diagnosis, there may need to be mental health clinician input into the FTTA. More information on assessment and support provided to detainees with a diagnosed mental health condition/s who are being removed from Australia, including the provision of medical escorts refer to Detention Health: Fitness to Travel Assessments − PI (DM-5028).

Furthermore, for detainees being removed from Australia, a Health Discharge Assessment (HDA) will be conducted. As part of the HDA process, the DHSP is required to identify any mental health issues of concern and document ongoing care and treatment required. The DHSP must ensure that a detainee being removed from Australia receives a minimum of 14 days' supply of all clinically indicated prescription medication (or a supply for a longer period as approved by the Department), fully translated medication administration instructions and a clear explanation of medication administration.
The Detention Health: Health Discharge Assessment − PI (DM-5261) provides a full description of continuity of care requirements for an individual being removed from Australia to be conducted as part of a HDA.

3.9 Training

Staff who work with detainees, including all DHSP and FDSP staff, must be provided training by their employer to identify and respond to detainees affected by trauma and mental illness, and to recognise the warning signs and risk factors related to self-harm and suicide.

This training should be nationally consistent and delivered in an ongoing format, incorporating initial training and at least an annual refresher.

The DHSP mental health clinicians providing support must have a demonstrated competency in clinical assessment, treatment planning and delivery of evidence based treatments for common mental disorders in

detainees. This is part of the overall responsibility of the DHSP to ensure that all health care practitioners operating in immigration detention are appropriately qualified and experienced.

Through this training, staff should be able to identify general signs of psychological distress which should trigger a mental health referral and review by the DHSP.

As a minimum, trauma and mental illness training for **all** staff must include the following issues:

- cultural awareness issues as they relate to mental state, expression of distress and self-harm
- recognising signs and symptoms of mental health distress
- awareness of the effects of trauma on mental and physical well-being
- routes and processes for referral to health services for persons for whom trauma risk indicators are identified, including the contents of this PI and related framework documents
- an awareness of the key risk and protective factors associated with self-destructive behaviour
- recognising signs and symptoms and events that would trigger an evaluation (or re-evaluation) of risk
- trauma informed care responses to engaging and communicating with trauma affected populations, including basic non-clinical interventions
- routes and processes for referral to health services for those experiencing distress, including the contents of this PI and related framework documents
- an awareness of suicide bereavement and postvention strategies and how to apply them in the context of immigration detention
- PSP processes as outlined in this PI and related framework documents, including periodic updates as a result of continuous quality improvement.

4. Statement of Expectation

The Australian Public Service (APS) Code of Conduct states that an APS employee must comply with any lawful and reasonable direction given by someone in the employee's Agency who has authority to give the direction under subsection 13(5) of the *Public Service Act 1999* (the Public Service Act).

Failure by an APS employee to comply with any direction contained in this PI document may be determined to be a breach of the APS Code of Conduct, which could result in sanctions under subsection 15(1) of the Public Service Act.

The Secretary's Professional Standards Direction, issued under subsection 55(1) of the *Australian Border Force Act 2015*, (the ABF Act) requires all IBP workers who are not employed under the Public Service Act to comply with any lawful and reasonable direction given by someone in the Department with authority to issue that direction.

Failure by an IBP worker who is not an APS employee to comply with a direction contained in this PI document may be treated as a breach of the Professional Standards Direction, which may result in the termination of their engagement under section 57 of the ABF Act. Non-compliance may also be addressed under the terms of the contract engaging the contractor or consultant.

All IBP workers who make decisions or exercise powers or functions under legislation have a duty to do so in accordance with the requirements of the legislation and legal principles.

5. Accountabilities and Responsibilities

Role	Description
ABF Detention Superintendent (Facility)	This position is responsible for the following: • chair daily local IDF site morning meeting with key stakeholders to share information and management of detainee's onsite and in support of the PSP • chair a weekly meeting with all detention SME review participants to assist in identifying any detainees who may be of concern due to mental health issues • chair weekly IMPRC meeting with key stakeholders to provide professional, balanced, timely and confidential advice to Facility Management regarding care and accommodation issues in relation to detainees placed at the Facility • maintain and update the 'watch list' of detainees who may be of concern • collate incident reports relating to self-harm, and provide these as inputs to PSP quality improvement processes • support the day-to-day management of detainees on SME. Work together with the DHSP and FDSP to: • provide an environment that seeks to prevent self-harm by reducing risk factors and enhancing protective factors, including activities and programs targeted at mental health promotion and prevention • implement suicide bereavement and postvention strategies to minimise the possible flow-on effect on others within the detention environment • participate in SME review team meetings and processes, including case reviews and ongoing quality improvement • share information about issues that may impact on the safety and wellbeing of the detainee or any service providers or departmental officers • keep complete, comprehensive, consistent, accurate and timely records.
Chief Medical Officer Branch	The Chief Medical Officer Branch (CMOB)provides proactive, strategy-led, clinically underpinned health and scientific advice, principally to the Department and ABF, but also across the wider portfolio of agencies The CMOB collaborates with external government agencies, both federal and in respective states and territories, as well as international counterparts, to share information and ensure consistency in the advice issued.

Role	Description
	The CMOB has lead accountability to ensure that policies, programs and related functions, including the provision of various health services, are informed by best clinical and scientific practice.
Child Wellbeing Operations Section	Where requested quality assure documents and processes in which IBP workers consider the best interests of children in immigration programs to confirm all relevant aspects of a child's circumstances have been included in decision-making provides policy guidance, assurance, training and support regarding the best practice for interacting with children and, in particular, the collection, inclusion and deliberation of information on the consideration of children's best interests which informs any decisions or actions made by IBP workers that affect a child.
Detention Health Policy and Program Support	This section is responsible for developing operational health policy and guidance to support the provision of health services in immigration detention. This involves timely and accurate advice, and the development of new policy that is underpinned by quality research, analysis, contextual awareness, clinical advice and stakeholder consultation across the ABF and the Department.
Detention Health Service Provider	• This section is responsible for the following: • chair the daily SME meeting • conduct initial and scheduled comprehensive mental health screening, as well as ad hoc assessments if a detainee displays deterioration in their mental state or undergoes a significant change in their situation that may exacerbate distress • provide input into the CIMP at the time of the mental health screening reviews and any other health care or behavioural related reviews • develop and implement self-harm protective and preventative strategies • provide advice to the FDSP about levels of risk and strategies for engaging and supporting detainees at risk of self-harm • seek out and use all available information when making assessments, providing care, and formulating advice regarding the management of detainees at risk of self-harm • with support from the SME review participants, provide a coordinated post-incident response in the event of a serious self-harm incident, including written reports to the Department on any triggers or contributing factors identified through post-incident debriefing • oversight and delivery of mental health interventions and outcome evaluation • implement suicide bereavement and postvention strategies, in the event of a self-harm incident occurring

Role	Description
	• work together with FDSP and departmental officers to provide an environment that seeks to prevent self-harm by reducing risk factors and enhancing protective factors, including activities and programs targeted at mental health promotion and prevention • participate in SME review meetings and processes, including case reviews and ongoing quality improvement • share information about issues that may impact on the safety and wellbeing of the detainee or any service providers or departmental officers, including providing input to the CIMP • keep complete, comprehensive, consistent, accurate and timely records.
Facilities and Detainee Services Provider	This section is responsible for the following: • conduct initial PSP self-harm risk assessment interviews (as appropriate) and refer detainees at risk of self-harm to the DHSP • be alert to early warning signs and seek immediate advice from the DHSP if risk of self-harm is suspected • follow clinical advice from the DHSP • engage with detainees identified as at risk of self-harm in a supportive way • development and review of IMPs and BMPs, including the CIMP • record observations of detainees on SME plans and ensure these are communicated to the SME review participants • respond to any attempted or committed self-harm or suicide incidents and submit incident reports to the Department • ensure that responsibility for supporting detainees at risk of self-harm is transferred and communicated effectively at shift changeovers. Work together with the ABF and the DHSP to: • provide an environment that seeks to prevent self-harm by reducing risk factors and enhancing protective factors, including activities and programs targeted at mental health promotion and prevention • implement suicide bereavement and postvention strategies to minimise the possible flow-on effect on others within the detention environment • participate in SME review meetings and processes, including case reviews and ongoing quality improvement • share information about issues that may impact on the safety and wellbeing of the detainee or any service providers or departmental officers

Role	Description
	• keep complete, comprehensive, consistent, accurate and timely records.
Status Resolution Support Services	The SRSS program provides support and assistance to individuals as they seek to resolve their immigration status and also to those who have resolved their immigration status and are transitioning to mainstream services in the Australian community.
Status Resolution Officer	Status Resolution Officers facilitate timely status resolution outcomes while managing risks to the community. They are responsible for determining support needs and the level of intervention required.

6. Version Control

Version number	Date of issue	Author(s)	Brief description of change
1.0	29/10/2019	Detention Health Policy and Program Support	Document created
1.1	7/03/2022	Detention Health Policy and Program Support	Approval of minor amendment
1.2	17/3/2023	Detention Health Policy and Program Support	Approval of minor amendment
2.0	17/5/2023	Detention Health Policy and Program Support	Approval following PPCF mandatory three (3) yearly comprehensive review
2.1	28/07/2023	Detention Health Policy and Program Support	Approval of minor amendment

Attachment A – Definitions

Term	Acronym (if applicable)	Definition
ABF Health Welfare Officer	HWO	An ABF Officer who monitors and reports on the provision of health services in immigration detention.
Behaviour Management Plan	BMP	A management plan developed and maintained by the FDSP in consultation with stakeholders (including the Department and the DHSP), which addresses a detainee's behavioural difficulties and sets out recommendations for support and engagement for that detainee in order to improve behaviour.
Challenging Behaviour		Behaviour of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy or behaviour which is likely to seriously limit or deny access to the use of ordinary community facilities.
Centralised Individual Management Plan	CIMP	A plan developed by the FDSP (in consultation with the DHSP and the Department) for the management of the detainee's health and wellbeing needs within an IDF.
Cognitive Impairment		Cognitive impairment is not an illness, but a description of someone's condition. It means they have trouble with things like memory or paying attention. They might have trouble speaking or understanding. They might have difficulty recognising people, places or things, and might find new places or situations overwhelming.
Detain		Has the same meaning as in subsection 5(1) of the *Migration Act* 1958 (the Act). Detain means: • take into immigration detention, or • keep, or cause to be kept, in immigration detention, and • includes taking such action and using such force as are reasonably necessary to do so. Note: This definition extends to persons covered by residence determinations (see section 197AC of the Act).
Detainee		As defined in subsection 5(1) of the Act which states, '*means a person detained*' and extends to persons covered by residence determinations (see section 197AC of the Act).
Detention Health Service Provider	DHSP	A DHSP is an organisation contracted by the Department to provide health services for persons under the care or control of the Department.

Facilities and Detainee Service Provider	FDSP	The FDSP is contracted by the Department to provide immigration detention, transport and escort, welfare and garrison services to immigration detainees on behalf of the Australian Government.
FDSP Facilities Operations Manager	FDSP FOM	An employee of the FDSP responsible for overall management of an IDF, including management of critical incidents and liaison with emergency services. The FDSP FOM also assists in the management of mental health issues within the IDF, for example by participating in PSP team meetings.
Health Induction Assessment	HIA	Conducted by the DHSP, the HIA is the health assessment of a person entering immigration detention to determine their health status.
Health Discharge Assessment	HDA	A clinical assessment completed by a health professional which details a detainee's physical and mental health status at point of transfer to RD or removal from held immigration detention, in order to facilitate continuity of health care.
Health Discharge Summary	HDS	Summarises the health status of a detainee and the health care provided to them while in immigration detention. The HDS, which promotes continuity of care, provides health information to future health professionals who will provide medical care to the detainee.
High Care Accommodation		High care accommodation refers to an environment where closer supervision and engagement of the detainee can be maintained. The concept of high care accommodation is not limited to a specified location. Some IDFs have accommodation areas that are suited for and routinely used as high care accommodation. If practical and necessary, high care accommodation can be facilitated in a detainee's current accommodation. In some cases, the transfer of detainees to another IDF with suitable accommodation may be necessary if the capability of an IDF to manage a detainee within that facility is exceeded.
Health Services Manager	HSM	The senior health advisor who heads the Clinical Governance Team, who is ultimately responsible for the activities of clinicians in the operating environment.
Immigration Detention		Has the same meaning as in subsection 5(1) of the Act: Immigration detention means *(a) being in the company of, and restrained by:* *(i) an officer; or* *(ii) in relation to a particular detainee – another person directed by the Secretary or the Australian Border Force (ABF) Commissioner to accompany and restrain the detainee; or* *(b) being held by, or on behalf of, an officer:*

		(i) in a detention centre established under this Act; or *(ii) in a prison or remand centre of the Commonwealth, a State or a Territory; or* *(iii) in a police station or watch house; or* *(iv) in relation to a non-citizen who is prevented, under section 249, from leaving a vessel – on that vessel; or* *(v) in another place approved by the Minister in writing* but does not include being restrained as described in subsection 245F(8A) or dealt with under paragraph 245F(9)(b). **Note 1:** Subsection 198AD(11) provides that being dealt with under subsection 198AD(3) does not amount to immigration detention. **Note 2:** This definition extends to persons covered by residence determinations (see section 197AC).
Immigration Detention Facility	IDF	An IDF is one of the following: an immigration detention centre (IDC) established pursuant to section 273 of the Act; immigration transit accommodation (ITA); or an alternative place of detention (APOD). APOD and ITA are policy terms which refer to places approved by the Minister (or delegate) in writing under paragraph (b)(v) of the definition of 'immigration detention' in subsection 5(1) of the Act.
Individual Management Plan	IMP	A plan developed by the FDSP (in consultation with the Department and the DHSP) for the management of a detainee within an IDF.
Individual Management Placement and Review Committee	IMPRC	A Committee that exists at each IDF, attended by the FDSP, DHSP and the Department at which (amongst other things) the FDSP and the Department will review, update and implement Individual Management Plans for applicable detainees (and BMPs, if any) and discuss placement options in relation to any detainees identified as being at risk of self-harm and/or suicide.
Informed Consent		Informed consent means that the information, proposal or procedure has been explained to the person in such a way that they are aware of the implications of providing or withholding consent and how their personal information will be handled if consent is or is not provided. Consent should be obtained each time there is a material change in circumstances. It should be specific, current and able to be withdrawn at any time. To ensure the detainee has given informed consent, the detainee should be given a full and detailed explanation of what is and what is not going to happen in a language they understand. Information cards and consent forms in various languages should be used to facilitate informed consent, as well as access to an interpreter. The interpreter can be

		requested by either the detainee or by the person undertaking the interview/meeting.
Keep SAFE (Support - Action Follow-up - Evaluation)	Keep SAFE	A series of standardised operational procedures which provide FDSP staff operational guidance for the SME requirements of the PSP, in the absence of a clinician for the care of people at increased risk of suicide and self-harm with an emphasis on prevention, support, engagement, autonomy and reintegration. Keep SAFE procedures contribute to the overall PSP.
DHSP Mental Health Clinician		For the purposes of this PI, mental health clinician refers to registered mental health nurses, GPs, Occupational Therapists (OTs), psychologists who are currently registered with a relevant professional body and working within the scope of their practice.
Mental Health Care Plan		A care plan, created by the DHSP, to provide clinical management of a detainee with a diagnosed mental health condition.
Mental Health Issues		A mental health issue interferes with a person's cognitive, emotional or social abilities. There are different types of mental health issues which result from interactions between the mind, body and environment, contributing to developing a condition.
DHSP Mental Health Team		The Mental Health Team is comprised of DHSP mental health clinicians. The team is responsible for the screening, identification, treatment and management of mental health conditions for detainees in immigration detention.
Minor		Has the same meaning as in subsection 5(1) of the Act, that is, a person who is less than 18 years old.
Observational Methods of Monitoring		For the purposes of this PI, Observational Method of Monitoring means closely observing a person's activities, conversations, mood changes and other sudden changes and providing meaningful written comments on what has happened with the person during the time of observation. SME observation must involve in person interaction and may also include intervening when a safety risk has been identified (i.e. a detainee tying a knot around a hang point). CCTV equipment must not be used for SME Observational Method of Monitoring. In situations identified by the DHSP and FDSP where the detainee poses a risk to officers, observational methods of monitoring may be adjusted for safety reasons on a case by case basis and as decided by the FDSP Duty Operations Manager in consultation with the DHSP.
Psychological Support Program	PSP	A program within immigration detention that identifies and manages the mental health welfare of all detainees. It is a clinically led intervention to assist in the management of risk of

		self-harm and suicide. Its day-to-day management is conducted by the DHSP-led PSP team, led by a senior mental health clinician and supported by representatives from the FDSP and the Department.
Post-Traumatic Stress Disorder	PTSD	PTSD is a stressor related disorder. It is a set of reactions that can develop in people who have been through a traumatic event which threatened, or was perceived to threaten, their life or safety, or that of others around them. For example, PTSD could arise as a result of a car or other serious accident, physical or sexual assault, war or torture, or natural disaster.
Postvention Strategies		A mental health intervention designed to support the friends and family of a person who has died by suicide or attempted serious self-harm, since they themselves may be at risk as a consequence.
Recording		To document written comments or observations in the Department's nominated IT system (for example CCMD Portal) or nominated template/file. In the case of Observational Methods of Monitoring it refers to documenting in writing what has happened with the person during the time of observation.
Residence Determination (Community Detention)	RD	RDs are provided for in section 197AB of the Act. The Minister may determine that specified persons are to reside at a specified place in the community instead of being detained at a place covered by the definition of ***immigration detention*** in subsection 5(1).
Safe and Secure Environment		For the purposes of this PI, safe and secure environment means an area within an IDF where the detainee can be constantly and regularly monitored and observed to mitigate any risk of self-harm and/or any other danger.
Supportive Monitoring and Engagement	SME	An enhanced level of monitoring under the PSP for a detainee identified as being at risk of self-harm and/or suicide. Techniques are tailored to the level of risk attributed to a detainee in regards to self-harm or suicide and subject to input from DHSP mental health clinicians. They are aimed at keeping the detainee safe. Monitoring and Engagement must be direct in person contact where clinically determined to be appropriate, such as for safety purposes. However, engagement may also occur through a mix of direct in person contact or phone calls. SME observation may also include intervening when a safety risk has been identified (for example, a detainee tying a knot around a hang point).

SME Plan		SME plans are aimed at keeping the person safe and encouraging their reintegration with the wider community in immigration detention, through a process of SME.
SME Review Meeting		A multi-stakeholder meeting, led by a DHSP mental health clinician supported by participants from the FDSP and the Department (including ABF), to discuss and review detainees on SME.
Suicide Bereavement Strategies		Strategies to help individuals understand and cope with the sadness and mourning that occurs after the loss of another person to suicide.
Trauma Informed Care		Care and engagement which recognises and acknowledges trauma and its prevalence, alongside awareness and sensitivity to its dynamics, in all aspects of service delivery.

Attachment B – Assurance and Control Matrix

1.1 Powers and Obligations

Implementation of this PI supports the requirements under *National Health Act 1953* and *Work Health and Safety Act 2011* but does not require any powers, delegations or authorisations.

1.2 Controls and Assurance

Related Policy	Work, health and safety governance arrangements – PS (HR-1230) Detention Health: Suicide Prevention Framework – PS (HR-4893) Child Safeguarding Framework – PS (BE-916)
Procedures / Supporting Materials	Best Practice for Interacting with Children – PI (BC-764) Detention Health: Health Discharge Assessment – PI (DM-5261) Detention Health: Fitness to Travel Assessments – PI (DM-5028) Detention Health: Health Screening and Management – PI (DM-6138) Detention Health: Privacy, Consent and Medical Records – PI (DM-5925) Detention Health: Placements and Transfers – PI (DM-5927) Detention Services Manual – Safety and security management – Incident management and reporting – PI (DM-616) Detention Services Manual – Detainee placement – Closer supervision and engagement of high-risk detainees (high care accommodation) – PI (DM-626) Detention Services Manual – Safety and security management – Behaviour management – PI (DM-5027) Detention Services Manual – Communication and engagement – Interpreting and translating services – PI (DM-600) Detention Services Manual – Programs and activities- Individual management plan and review – PI (DM-4842) Vulnerable Persons – SM (SM-5337) Detention Health: Responding to Food/Fluid Refusal – SOP (DM-3284) Detention Health: Responding to Self-Harm – SOP (DM-3283) Detention Services Manual – Safety and security management – Debriefing – SOP (DM-3304) Detention Health: Health Screening of Minors – SOP (DM-3278) SRSS OPM V8 (ADD2019/851260) What is Mental Illness? American Psychiatric Association World Mental Health Report - World Health Organization Signs & symptoms of anxiety - Black Dog Institute Signs & symptoms post-traumatic stress disorder - Black Dog Institute

	Emotional and Psychological Trauma - HelpGuide.org Framework for Suicide Risk Assessment and Management - NSW Health
Training/Certification or Accreditation	No specialist training required
Other required job role requirements	NIL
Other support mechanisms (e.g. who can provide further assistance in relation to any aspects of this instruction)	Queries can be submitted to health@homeaffairs.gov.au
Escalation arrangements	Escalation of concerns or issues regarding the provision of mental health services can be sent to the Director, Detention Health Policy and Assurance Section via the health@homeaffairs.gov.au. The email should be marked to the attention of the Director in the subject heading.
Recordkeeping (e.g. system based facilities to record decisions)	All decisions regarding the provision of mental health services for detainees in immigration detention, are to be saved in the Departments electronic document records management system (EDRMS).
Program or Framework (i.e. overarching Policy Framework or Business Program)	Detention Health: Health Services and Delivery Standards – PS (DM-5717)
Job Vocational Framework Role	This PI applies to: Strategic Policy – Policy Officer Compliance and Regulation – Detention Operations

Attachment C – Consultation

1.1 Internal Consultation

- All Departmental Staff
- Chief Medical Officer Branch
- Child Wellbeing Operations Section
- Detention and Removals Operational Section
- Detention Health Operations
- Detention Operational Policy Section
- Detention Placements Section
- Integrity and Professional Standards Branch
- Integrity and Professional Standards Branch
- Legal Group.
- Onshore Contracts Section
- Onshore Health Contracts Section
- Privacy and Information Disclosure Section
- Staff Health and Wellbeing Section
- Status Resolution Capability Section
- Status Resolution Support Services Contracts Section

1.2 External Consultation

- Consultant Psychiatrist
- International Health and Medical Services (IHMS)
- SERCO

Australian Government
Department of Home Affairs

OFFICIAL: Sensitive

Detention Services Manual – Detainee placement – Closer supervision and engagement of high risk detainees (high care accommodation)

Procedural Instruction

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Document Contact	Detention Operational Policy *detention.policy@abf.gov.au*

Table of Contents

1. Purpose

1.1. Introduction

1.1.1. This Procedural Instruction (PI) provides guidance on the use of closer supervision and engagement of high risk detainees. For the purpose of this document, 'high risk' refers to a detainee's likelihood to challenge or damage the good order of an immigration detention facility (IDF), be at risk of harm to themselves, others, or requests to be separated from the general detainee cohort – this is distinct from the FDSP risk assessment.

1.1.2. Separating high risk detainees from the general population or their family (in high care accommodation (HCA)) in an IDF should only be used as a last resort and for the shortest practicable time.

1.1.3. If the high risk detainee is a minor, the minor is detained only as a measure of last resort, for the shortest appropriate period of time and in the least restrictive form appropriate to a minor's circumstances. If a minor is accompanied by family members, the family unit must be maintained if possible; except in cases where it is contrary to the minor's best interests.

1.1.4. **Under no circumstance can a detainee be placed under closer supervision and engagement arrangement as a punitive measure.** A person's detention under closer supervision and engagement continues to be an administrative process and care must be taken when engaging processes which could be construed as penalising detainees.

1.1.5. This PI relates to and must be implemented in conjunction with *DSM – Detainee placement – Closer supervision and engagement of high risk detainees (High care accommodation) – SOP (DM-3301).*

2. Scope

2.1. In Scope

2.1.1. This PI provides guidance to departmental officers and contracted service providers working in an IDF in relation to:

- request and approval for placement under closer supervision and engagement
- implementing involuntary closer supervision and engagement
- implementing voluntary closer supervision and engagement
- record keeping and
- concluding closer supervision and engagement arrangements

2.1.2. This PI applies to the 'National Detention Placement Model' placement options within the immigration detention network (IDN) in Alternative Places of Detention (APOD) (Tier 2) and High Security Detention (Tier 3).

2.1.3. This PI provides a brief and general overview only, of the Tier 4 placements.

2.1.4. This PI also includes the template *High Care Accommodation Placement* – Annex A.

2.2. Out of Scope

2.2.1. This PI does not cover procedures in relation to:

- comprehensive processes for external arrangements of Tier 4 (Specialist Care Provider or Corrections) specific placements
- the use of specific infrastructure to accommodate high risk detainees
- initial placement of newly arrived detainees. This is to be dealt with in accordance with:
    - *DSM – Detainee placement – Assessment and placement of detainees in IDFs – PI (DM-5126)*
    - *DSM – Detainee placement – Detainee placement – SOP (DM-3248).*
- the placement of detainees in accommodation arrangements for health reasons such as medical and quarantine
- detainees separated for medical health reasons. However, all high risk detainees will be reviewed by the Health Services Manager (HSM) who will contribute to their management. For further information and guidance regarding health, contact:
    - *health@homeaffairs.gov.au* - for policy instructions and/or guidance
    - *detention.health@abf.gov.au* - for operational matters and
    - *IDG.Healthcontracts@homeaffairs.gov.au* - for all onshore health services contract related matters, including Christmas Island.

3. Procedural Instruction

3.1. High risk detainees

3.1.1. High risk detainees are those who:

- pose a significant risk to themselves, to the good order and security of an IDF and the safety of people within the IDF or
- are vulnerable and for whom relocation from the general detainee population has been recommended, including as part of a mental health plan or transfer to a correctional facility under a Tier 4 ‘Specialist Care Provider’ or ‘Corrections’ placement arrangement or
- request to be separated on a short term basis for respite from other detainees or for ‘time out’.

3.2. Closer supervision and engagement

3.2.1. Closer supervision and engagement refers to the close control and intensive approach in the management of high risk detainees, irrespective of placement location or arrangement. It is applied while maintaining the respect for and the dignity of the detainee within a safe and secure environment.

3.2.2. Placing a detainee under closer supervision and engagement will regulate their movement within the IDF, their access to activities or services and may involve their relocation to more suitable accommodation. At all times closer supervision and engagement is to be used in the best interests of a detainee and for the shortest practicable time.

3.3. High care accommodation

3.3.1. High care accommodation refers to an environment where closer supervision and engagement of the detainee can be maintained. The concept of high care accommodation is not limited to a specified location. Some IDFs have accommodation areas that are suited for and routinely used as high care accommodation. If practical and necessary, high care accommodation can be facilitated in a detainee's current accommodation. In some cases, the transfer of detainees to another IDF with suitable accommodation may be necessary if the capability of an IDF to manage a detainee within that facility is exceeded.

3.4. Tier 4 placement

3.4.1. Detention facilities are not designed to accommodate detainees with extreme safety and security risk profiles, or individuals who have a complex vulnerability profile. Due to the extreme risk they pose to themselves or to others, the capability to accommodate detainees with these profiles should be outsourced to providers with the relevant expertise to manage these individuals.

3.4.2. Tier 4 'Specialist Care Provider' or 'Corrections' placement is intended for a very small number of detainees who would normally be accommodated in Tier 3. This may include, but is not limited to:

- individuals who present an extreme risk of violence and would be more appropriately detained in a prison
- individuals with severe mental or physical health issues requiring specialist medical placement
- end of life placement or complex vulnerability or
- juveniles who require placement in a juvenile facility.

3.4.3. The current IDN will not be configured to accommodate detainees who are more appropriately managed by specialist providers.

3.5. No use of dry celling arrangements

3.5.1. The use of 'dry celling' arrangements **must not** be used in the IDN.

3.5.2. 'Dry celling' is a term used in the corrections environment in reference to a practice whereby prisoners are placed in restrictive detention (away from the general population) with no access to running water or a flushable toilet. The aim of this practice is to have prisoners relinquish contraband items, such as illicit drugs.

3.6. Self-agency

3.6.1. Self-agency is the self-awareness of being able to initiate, execute and control one's own actions and is tightly linked to the sense of ownership over actions.. In the context of a detainee, self-agency includes the ability to manage emotions, to understand and acknowledge the reason for being in immigration detention, to understand the consequences of certain behaviours and the impact those behaviours may have on themselves and others. Self-agency is furthered by including detainees in decision making processes affecting their placements in immigration detention.

3.6.2 Implementation of closer supervision and engagement should incorporate the promotion and support of self-agency by detainees to:

- motivate and prepare for reintegration to the main detention population as soon as practicable
- encourage positive changes in attitude and behaviour and
- address the risks they pose.

3.7. Guiding principles of closer supervision and engagement

3.7.1 The following guiding principles are to be considered when planning and implementing closer supervision and engagement.

Placement in a closer supervision and engagement arrangement as a last resort

3.7.2. Placement of detainees in a closer supervision and engagement arrangement, regulating their movement within the facility and their access to activities or services, should only be used as a last resort and when other strategies to manage their vulnerabilities, behaviour or the risk they pose have not succeeded. The aim is to safely reintegrate the detainee to the main detention population of the IDF following the cessation of the closer supervision and engagement arrangements.

Collaborative team work

3.7.3. A collaborative team-based approach between the Department of Home Affairs (the Department) including the Australian Border Force (ABF) and contracted service providers enhances the management, care and experience of high risk detainees requiring closer supervision and engagement.

Clear provision of information

3.7.4. Effective communication between the Department, contracted service providers and detainees is an integral component of the planning and implementation of the closer supervision and engagement process.

Promotion of self-agency

3.7.5. Closer supervision and engagement will provide opportunities for detainees to maintain a level of self-agency, offer opportunities to participate and ultimately to reintegrate with the general detention population.

Positive and supportive response

3.7.6. Closer supervision and engagement is **not punitive** and should not be used as an incentive to change detainee behaviour. It is to be used to support high risk detainees until they no longer pose a significant risk to themselves, to others in the IDF or to the good order of the IDF.

Planning based on individual assessment

3.7.7. Detainees should only be subject to closer supervision and engagement as necessary to ensure their safety or that of others in the IDF. Planning is to contain clearly defined and reviewable milestones based on individual assessment. Planning should identify the type and level of care required, including the frequency of checks undertaken on individuals to ensure they are safe and well. This care should not increase the risks of psychological harm or behavioural change through excessive monitoring.

Flexible application of this instruction

3.7.8. Application of this instruction should be consistent with the operational, legal and administrative requirements of the Department and its contracted service providers, while supporting the needs of the detainee in a closer supervision and engagement arrangement and of other persons within the IDF.

3.7.9. In applying this PI, departmental officers and contracted service providers are to be mindful of the different objectives in using closer supervision and engagement of high risk detainees who are vulnerable, as compared to high risk detainees who pose a risk to the security and good order of the IDF.

Medical and health support

3.7.10. As a component of the collaborative partnership approach between the Department, Detention Health Service Provider (DHSP) and the FDSP in the management of high risk detainees requiring closer supervision and engagement, the provision of medical and mental health support will be assessed, detailed and incorporated into the appropriate closer supervision and engagement planning for the detainee.

Placement timeframe

3.7.11. Detainees should be placed under closer supervision and engagement for the shortest practicable time. Placement is considered in **24 hour** segments. Placements **exceeding 72 hours** requires an authorisation by the Commander, National Immigration Detention (Operations) as outlined in **3.11.** *Authorisation*.

Minimising restrictions

3.7.11. Based on risk assessment, a detainee's placement under closer supervision and engagement should be as free of restrictions as is safe and practicable.

External referral

3.7.12. A transfer under Tier 4 'Specialist Care Provider' or 'Corrections' placement arrangements occurs when a detainee presence in the IDF exceeds the capability of the IDF to manage them. See section **3.4**. *Tier 4 placement.*

3.8. Use of collaborative planning and management

3.8.1. In line with the *Guiding Principles*, Departmental, FDSP and DHSP staff are to use a collaborative approach for the assessment and planning toward the implementation of closer supervision and engagement for the management of high risk detainees. Using this collaborative approach, stakeholders should consider the detainee's current requirements and needs, incorporate these needs into their planning, and address issues on a prioritised, systematic basis.

3.8.2. This consultative approach will continue throughout the period that closer supervision and engagement is required, with regular meetings between all parties to gauge the detainee's progress against established milestones, to reassess and, if required, revise planning.

3.8.3. In addition, the detainee involved is to be kept up-to-date and informed of all decisions by the consultation team. The detainee should also be advised of, and have full access to, complaints mechanisms.

3.8.4. For further guidance, refer to *DSM – Detainee placement – Assessment and placement of detainees in IDFs – PI (DM-5126).*

3.9. Assessing detainees prior to providing closer supervision and engagement

3.9.1. Unless circumstances require an emergency or immediate response, the decision to implement closer supervision and engagement to manage high risk detainee/s should be based on an assessment of the detainee/s conducted by the relevant stakeholders to ensure planning is in line with the guiding principles of this PI.

3.9.2. Assessment will include the determination of:

- the level and type of risks posed by the detainee
- the detainee's history of compliance while in detention
- the detainee's identified vulnerabilities and/or health considerations and
- the support and services which will assist the detainee.

3.10. Planning

3.10.1. Using the assessment of the detainee, management planning will emphasise:

- constructive interaction with the detainee
- provision of identified support and services required by the detainee
- allowing for appropriate respite from other detainees or for 'time out' and
- promotion and support of self-agency.

3.10.2. Dependent on the level of risk and the urgency, high risk detainees should be included in the consultation process during the development of their management plan. The aim of this approach is to gain their co-operation, for them to have a 'voice' during the planning, and to ensure they understand the:

- reasons and purpose for their management plan
- milestones they need to achieve under the plan
- consequences of not achieving their milestones
- intended outcomes of the plan and
- complaint mechanisms available to them.

3.10.3. Detainees managed under this PI are to have access to health care facilities and programs and activities targeted to their needs, unless access to these services interferes with the nature of the closer supervision and engagement or poses a risk to the safety and security of the IDF.

3.10.4. In the event that these services interfere with the nature of the closer supervision and engagement or poses a risk to the safety and security of the IDF, all reasonable steps should nevertheless be taken to provide these services to detainees while under closer supervision and engagement (for example, through providing separate access to the health care facility or running separate or alternative activities).

3.11. Authorisation

3.11.1. Placement of a detainee under closer supervision and engagement for **less than 24 hours** requires the approval from the ABF Detention Superintendent (Facility) or delegate.

3.11.2. Where closer supervision and engagement placement **exceeds 24 hours**, the ABF Detention Superintendent (Facility) or delegate is required to review the placement **every 24 hours** thereafter, up to **72 hours**. For placements **past 72 hours**, seek approval from the Commander, National Immigration Detention (Operations) (see section **3.20.** *Review of detainees placed under closer supervision and engagement*).

3.11.3. The ABF Detention Superintendent (Facility), departmental officers and contracted service providers are to ensure that all records pertaining to the authorisation of initial and ongoing placement under closer supervision and engagement, including any approval emails are recorded in Content Manager (formerly TRIM) with the relevant Content Manager file (TRIM file number) noted in the CCMD portal.

3.13. Urgent cases, incident and emergency management

3.13.1. In urgent cases or in response to an incident or emergency, it may be necessary to move high risk detainees into a controlled environment immediately within the IDF on an unplanned basis. This is to ensure their immediate safety and the safety of others while options on next steps for their care and management are considered.

3.13.2. In such cases, appropriate action should be taken by the FDSP to provide an effective first response to the incident or emergency. A truncated emergency placement process is acceptable if closer supervision and engagement placement is considered necessary. A request to implement closer supervision and engagement placement is to be made within **one (1) hour** of the detainee being taken into a controlled environment. An emergency placement can be triggered by either the Superintendent, National Detention Placements, ABF Detention Superintendent (Facility), the FDSP or HSM.

3.13.3. For further guidance, refer to:

- *DSM – Detainee placement – Assessment and placement of detainees in IDFs – PI (DM-5126)* and
- *DSM – Detainee entry and exit –Transfers of detainees – PI (DM-618).*

3.14. Detainees who pose a significant risk

3.14.1. Managing detainees who pose a significant risk to themselves, to others in the IDF, or to property, requires a clear and transparent approach. Implementation of a closer supervision and engagement arrangement for these detainees should include:

- explanation of the reason/s for the use of closer supervision and engagement
- explanation of the consequences of the detainee's behaviours or actions
- explanation of what action will be taken and how their actions or behaviour may affect their status resolution
- explanation on limiting or restricting the detainee's access to other detainees where necessary for the safety of the individual and other detainees (**note:** this must not be used as an incentive to change the detainee's behaviour) and
- consideration of relocation to HCA.

3.15. Placing detainees under closer supervision and engagement

3.15.1. Closer supervision and engagement is to be used only as a last resort and on a short-term basis, when other intervention methods have been unsuccessful or assessed as unsuitable.

3.15.2. Placement under closer supervision and engagement will depend on:

- advice from a qualified medical professional
- the assessed level of risk posed by the detainee
- the limitations required on their movements (for example, access to other detainees, activities and non-essential services) and
- the availability of suitable accommodation.

3.15.3. Placement under closer supervision and engagement may take place in circumstances including but limited to where a high risk detainee:

- exhibits aggressive and/or unlawful behaviours and repeatedly refuses an order or direction to cease such behaviour
- exhibits extreme risks in their behaviours and/or actions (ie. violent, destructive, etc.) and is pending transfer to a Tier 4 'Specialist Care Provider' or 'Corrections' placement (**note:** transfers to a mental health facility is normally under the Mental Health Act as part of a hospital transfer. These are **not** normally Tier 4 placements. Mental Health placements are managed by the local hospitals) or
- requests placement in a closer supervision and engagement arrangement and is assessed as requiring temporary respite (voluntary placement).

3.15.4. Moving a detainee to a closer supervision and engagement arrangement will include:

- consultation between the Department, DHSP, the FDSP and the detainee to plan for the detainee's placement under closer supervision and engagement, including a plan for the future cessation of the arrangement needs to be established as soon as practicable.
- a plan with clear, written explanation of the reasons why it was necessary to place the detainee under closer supervision and engagement to protect the safety and security of detainees or the IDF
- in the plan (if relevant), explanation of why it was necessary to place the detainee away from their usual placement arrangement (including any accommodation that may be perceived as 'isolation')
- the detainee being made aware of the reasons for their relocation, in a language they understand
- observation of all legal obligations relating to all people involved in the relocation process
- any planned or unplanned use of force occurring be in accordance with *DSM– Safety and security management – Use of force – PI (DM-623)*. During relocations, planned use of force must be video recorded. Unplanned use of force should be video recorded where operationally practicable.
- the use of monitoring protocols to ensure the management of the safety and wellbeing of the detainee while under closer supervision and engagement.

3.15.5. **Isolation may only be used in the most extreme cases and must be overseen by the appropriate departmental senior officer and health service provider** as it may be perceived by detainees as punitive and/or an automatic consequence of demonstrating their emotions

through their behaviour. It may discourage honest communication in future, or lead to further disruptive behaviour.

3.15.6. In the event of an incident resulting in a detainee placement under closer supervision and engagement, the incident must be recorded and reported through OPTICS (formerly BIMS/POMS).

3.15.7. For further guidance, refer to:

- *DSM – Safety and security management – Audio visual recording – PI (DM-614)*
- *DSM – Safety and security management – Use of force – PI (DM-623)*
- *DSM – Detainee placement - Closer supervision and engagement of high risk detainees (High care accommodation) – SOP (DM-3301)*
- *DSM – Safety and security management – Incident management and reporting – PI (DM-616).*

3.16. Health considerations

3.16.1. The three (3) key risks to a detainee's physical and mental health, which are to be subject to ongoing review while under closer supervision and engagement, are:

- pre-existing health conditions
- the actions of the detainee prior to relocation to closer supervision and engagement and
- the location of the accommodation used.

3.17. Detainees requesting voluntary placement under closer supervision and engagement

3.17.1. A detainee may voluntarily seek to be placed in closer supervision and engagement, separating them from the main detention population. However, closer supervision and engagement placement should only be made available on approval by the Department (see section **3.11** *Authorisation*) following an assessment by the Department, FDSP and HSM of:

- the detainee's wellbeing and level of care required
- availability of suitable accommodation and
- consideration of associated operational priorities.

3.17.2. If relocation is determined to be appropriate and written approval is given, it is to be utilised only on a short-term basis.

3.17.3. Any request to be placed under closer supervision and engagement should be made in writing by the detainee. If this is not possible, it must be recorded in writing by the ABF or FDSP officer to whom the detainee makes the request.

3.18. Minors

3.18.1. Minors are detained only as a last resort, for the shortest practicable time and in the least restrictive form appropriate to a minor's circumstances. If a minor is accompanied, the minor's family unit, if possible and appropriate, must be maintained.

Accompanied minors

3.18.2. Accompanied minors will not be separated from their family, guardian/s or carer/s, unless separation is required to protect the minor from harm or the risk of suffering.

3.18.3. Multiple risk factors can affect the behaviour of minors in immigration detention. If the parent/s, guardian/s or carer/s cannot manage to correct inappropriate behaviour by a minor, it may be necessary for the FDSP to intervene to provide guidance and feedback in collaboration with the parent/s, guardian/s or carer/s and the DHSP.

3.18.4. The intervention should not undermine the parent's, guardian's or carer's responsibilities for, or relationship with, the minor. The intervention should support family autonomy and be consistent with the child-centric approach outlined in the:

- *Child Safeguarding Framework – PS (BE-916)* and
- *Best Practice for Interacting with Children – PI (BC-764)*.

3.18.5. Interventions of this nature will fall within the scope of the FDSP's management planning for the family and must include input from the ABF Detention Superintendent (Facility) and relevant child wellbeing officer (CWO). For assistance, contact Child Wellbeing Operations at *childwellbeingoperations@homeaffairs.gov.au*.

3.18.6. Where closer supervision and engagement is considered appropriate and beneficial for a minor whose guardian is not in immigration detention, their guardian should always be consulted.

3.18.7. For minors attending school, consultation with the school and Child Wellbeing Operations, in coordination with the parent/s, guardian/s or carer/s, may also be required.

Unaccompanied minors (UAMs)

3.18.8. Closer supervision and engagement in HCA (separated from the main population of the IDF) may be used for UAMs, but **not** to isolate them **and only as a last resort** when closer supervision and engagement has not been successful while the UAM has been accommodated within the main population of the IDF.

3.18.9. If placement under closer supervision and engagement in HCA is under consideration for a UAM, for whom the Minister is the guardian under the *Immigration Guardianship of Children Act 1946* (the IGOC Act), the UAM's IGOC delegate should be involved in any discussion of this placement.

3.19. Review of detainees placed in closer supervision and engagement arrangements

3.19.1. In having a collaborative team-based approach to managing high risk detainees, the review of each case should use established departmental, DHSP and FDSP planning requirements.

3.19.2. All parties should work together to conclude the placement of a detainee from under closer supervision and engagement arrangement as soon as practicable.

3.19.3. Detainees **must not** be placed in a closer supervision and engagement arrangement for more than **24 hours** without review, including a health review by the DHSP. Commander, National Immigration Detention (Operations) **MUST** review and make a decision on the recommendation for a detainee to remain under closer supervision and engagement for each placements past **72 hours** and then every **24 hours** until the placement has concluded.

3.19.4. For further guidance, refer to *DSM – Detainee placement – Closer supervision and engagement of high risk detainees (High care accommodation) – SOP (DM-3301).*

3.20. Concluding closer supervision and engagement arrangements

3.20.1. The placement of a detainee under a closer supervision and engagement arrangement is concluded for **involuntary placement** when, the FDSP and DHSP agree that there is no longer a risk to the safety and security to the detainee, to others or to the IDF and therefore the placement is no longer necessary, or the ABF Detention Superintendent (Facility) or Commander, National Immigration Detention (Operations) directs the termination of the placement.

3.20.2. The placement of a detainee under a closer supervision and engagement arrangement is concluded for **voluntary placement** when, the detainee requests to leave closer supervision and engagement and the FDSP and DHSP agree that the placement is no longer necessary to protect the safety and security of the detainee or the IDF, or the ABF Detention Superintendent (Facility) or Commander, National Immigration Detention (Operations) declines to extend a voluntary placement.

3.20.3. The termination of closer supervision and engagement arrangements and the reasons for termination **must** be recorded in writing by the ABF using the template *High Care Accommodation Placement* – Annex A.

3.21. Record keeping

3.21.1. Record keeping associated with all closer supervision and engagement arrangement must be accurate, timely and complete.

4. Accountabilities and Responsibilities

Role	Description
Commander, National Immigration Detention (Operations)	Consider and make a decision on all closer supervision and engagement requests for detainees for the initial period of more than **72 hours** and approve the placement thereafter each **24 hours** until the placement is concluded.
ABF Detention Inspector (Facility)	Perform the responsibilities of the ABF Detention Superintendent (Facility) when on-call only.
ABF Duty Officer	The on-call ABF Duty Officer is responsible for approval of detainee placements under closer supervision and engagement in the absence of the ABF Detention Superintendent (Facility). Written approval from the ABF Detention Superintendent (Facility) can be provided retrospectively.
ABF Detention Superintendent (Facility)	• Decide and review voluntary and involuntary closer supervision and engagement placements every **24 hours**, up to **72 hours**. • Seek authorisation from Commander, National Immigration Detention (Operations) for involuntary and voluntary closer supervision and engagement placements that exceed **72 hours,** and then every **24 hours** thereafter.

Role	Description
	• Review voluntary and involuntary closer supervision and engagement placements upon expiration of the closer supervision and engagement period. • Approve planned use of force by the contracted service provider. • Maintain records of all closer supervision and engagement decisions and actions using the template *High Care Accommodation Placement* – Annex A.
Detention Health Service Provider	• Advise on the appropriateness of placing detainees in closer supervision and engagement placements. • Assess the need to enact supportive monitoring and engagement as part of the placement process. • Recommend appropriate detainee observation intervals depending on the circumstances of the placement and the mental health and wellbeing of the detainee. • Assess the health of detainees in closer supervision and engagement placements every **24 hours** and upon release.
Facilities and Detainee Service Provider	• Submit requests for closer supervision and engagement placements to the ABF Detention Superintendent (Facility). • Initiate the closer supervision and engagement process and actions associated with the placement as agreed by all stakeholders involved in the decision process. • Identify any concerns regarding the well-being of the detainee or the security and good order of the facility. • Engage with detainees and ensure their safety while in a closer supervision and engagement placement. • Monitor detainees in in accordance with agreed and specified detainee observation intervals. • Document observations and notify relevant stakeholders of changes in behaviour, positive or negative. • Seek approval for any planned use of force from the ABF Detention Superintendent (Facility). • Record the use of force on video and audio. • Make collaborative written recommendations to the ABF Detention Superintendent (Facility) regarding the exit from the closer supervision and engagement arrangement. • Release detainee/s from closer supervision and engagement placements when no longer necessary and as directed by the ABF Detention Superintendent (Facility).

5. Version Control

Version number	Date of issue	Author(s)	Brief description of change
2.0	01/06/2017	Detention and Removal Operational Policy	Update of detention instructions to reflect PPCF requirements.
3.0	26/05/2017	Detention and Removal Operational Policy	Reviewed as per Deputy Commissioner's request for 'extraordinary review'. Relevant recommendations from 'Post Action Review – Dry Celling Incident at Maribyrnong Immigration Detention Centre – 25 September 2015' have been incorporated.
4.0	25/07/2018	Detention and Removal Operational Policy	Consideration of feedback provided from legal review.
5.0	30/07/2018	Detention and Removal Operational Policy	Final Inspector/Superintendent review.
6.0	01/08/2018	Detention and Removal Operational Policy	Update post Superintendent review.
7.0	22/10/2021	Detention Operational Policy	Includes adjustment for initial placement approval from Commander to Superintendent for periods less than 72 hours. Inclusion of the template for High Care Accommodation Placement – Annex A. PPCF mandatory three (3) year review. Updates: • PPCF template • policy owner (section name) • terminology

Attachment A – Definitions

The terms and their accompanying definitions that have specific meanings in the context of the suite of detention instructions is at *DSM – Glossary – SM (DM-5249).*

Attachment B – Assurance and Control Matrix

1.1. Powers and Obligations

Please Note: Officers exercising any powers, delegations or authorisations outlined in this PI (listed here) must check the latest delegation advice on the Intranet or the relevant instrument in LEGEND to ensure they currently hold the applicable power, delegation or authorisation.

Legislative Provision			Is this a delegable power?	If delegable, list the relevant instruments of delegation
Legislation	Reference (e.g. section)	Provision		
Australian Border Force Act 2015 (ABF Act)	subsections 44(3) and 45(3)	Disclosure of Immigration and Border Protection (IBP) information.	yes - authorisation	*Instrument of Delegation 2017* (DEL 17/082) (delegation applies to IBP workers of the Department of Home Affairs) *Australian Border Force (Secretary) No 1 of 2018 (ABF (s) No. 1 of 2018)* (delegation applies to IBP workers in the ABF) Authorisation to disclose Immigration and Border Protection information *DEL18/004* (Department of Home Affairs) Authorisation to disclose Immigration and Border Protection information - ADD2020/5712705 (applies to IBP workers of the ABF excluding OSB JATF)
	subsection 55(1)	The Secretary may, by writing, give directions to IBP workers in connection with the administration and control of the Department.	no	n/a
Immigration (Guardianship of Children) Act 1946)	subsection 5(1)	Delegation	yes	*Immigration (Guardianship of Children) Delegation (ADMIN 22/102) 2022*

Legislative Provision			Is this a delegable power?	If delegable, list the relevant instruments of delegation
Legislation	Reference (e.g. section)	Provision		
Migration Act 1958	paragraph 5(1)(g)	Definition of an officer	yes - authorisation	*Migration (Migration Officers) Authorisation 2021/001* (ADMIN21/001)
Privacy Act 1988	schedule 1	Australian Privacy Principles	no	n/a
Public Service Act 1999	section 13	APS Code of Conduct	no	n/a
Public Interest Disclosure Act 2013	section 7	Provides a means for protecting public officials from adverse consequences of disclosing information that, in the public interest, should be disclosed and provides for their investigation.	yes	Instrument 1 of 2020

1.2. Controls and Assurance

Related Policy	*Child Safeguarding Framework – PS (BE-916)* *DSM – Detainee placement - Closer supervision and engagement of high risk detainees (High care accommodation) – SOP (DM-3301)* *Guardianship of certain non-citizen minors – PS/PI (VM-6457)* *Suicide Prevention Framework – Immigration Detention Facilities – PS (HR-4893)* *Records Management – PS (TI-1094)*
Procedures / Supporting Materials	*Best Practice for Interacting with Children – PI (BC-764)* *Mental Health – PI (DM-6320)* *DSM – Detainee placement – Assessment and placement of detainees in IDFs – PI (DM-5126)* *DSM – Safety and security management - Audio visual recording – PI (DM-614)* *DSM – Detainee entry and exit – Transfers of detainees – PI (DM-618)* *DSM – Safety and security management – Use of force – PI (DM-623)* *DSM – Safety and security management - Incident management and reporting – PI (DM-616)* *DSM – SOP – Detainee placement – Detainee placement – SOP (DM-3248)* *DSM – Definitions – Supporting Material (DM-5249)*

Training/Certification or Accreditation	FDSP officer specific: (Use of force) Initial Training Course (ITC) – all FDSP officers Control Incident using Defensive Tactics (CSCSAS009) Psychometric testing Certificate II in Security (CPP20212) Control persons using empty hand techniques (CPPSEC3013A) Emergency Response Team (ERT) training – selected FDSP officers All FDSP officers undertake refresher training at least every two (2) years including reassessment to ensure their skills remain at the required level. Working with Vulnerable People registration
Other required job role requirements	Delegations Security clearance Departmental systems access
Other support mechanisms (e.g. who can provide further assistance in relation to any aspects of this instruction)	If you require further advice or assistance, or would like to provide feedback in relation to this PI, please contact the Detention Operational Policy section at *detention.policy@abf.gov.au*.
Escalation arrangements	Escalation of concerns or issues regarding this PI can be sent to Superintendent, Detention Operational Policy at *detention.policy@abf.gov.au*.
Recordkeeping (e.g. system based facilities to record decisions)	All records created as a result of this procedure must be managed in accordance with the *Records Management – PS (TI-1094)*. Records created as a result of this procedure must be saved in TRIM or an approved business system (i.e. CCMD, OPTICS, etc).
Program or Framework (i.e. overarching Policy Framework or Business Program)	Immigration Detention Facilities and Detainee Service Contract National and site-specific work instructions
Job Vocational Framework Role	Detention Operations – Job Code 30001731

Attachment C – Consultation

1.1. Internal Consultation

1.1.1. The following internal stakeholders were consulted in the development of this PI:

- Child Wellbeing Operations Section
- UHM and Guardianship Section
- National Detention Operations, including regional commands
- Detention Strategy and Risk Section
- Legal Group
- Privacy & Information Disclosure Section
- Onshore Contracts Section
- Status Resolution Program Management and Capability Section
- Integrity and Professional Standards Branch
- Workforce Health and Safety Section

1.2. External Consultation

1.2.1. The following external stakeholders were consulted in the development of this PI:

- Serco

Australian Government
Department of Home Affairs

Annex A. High Care Accommodation Placement

High-care accommodation (HCA) refers to an environment where a higher degree of supervision and engagement of a high-risk detainee can be maintained. While immigration detention facilities (IDFs) may have accommodation areas that are suited for and routinely used as HCA, the concept of HCA is not limited to a specified location.

High-risk detainees are those who:

- pose a significant risk to the good order and security of an IDF and the safety of people within the IDF
- are vulnerable and for whom relocation from the general detainee population has been recommended, including as part of a mental health plan or transfer to a correctional facility under a Tier 4 placement arrangement or
- seek to be separated on a short term basis for respite from other detainees or for 'time out'.

Placement in HCA may be voluntary or involuntary.
This template must be used in <u>all</u> instances where a detainee is separated from the general population, except in the instance of an emergency placement.

Separating detainees from the general population (in HCA) in an IDF should only be used as a last resort and for the shortest practicable time. **Under no circumstance can a detainee be relocated to a HCA placement as a punitive measure.** A person's placement in HCA continues to be an administrative process and care must be taken about instituting processes which could be construed as penalising detainees.

Summary of HCA placement delegations

Initial placement	Superintendent Approval
Review every 24 hours up to 72 hours	Superintendent Approval
Over 72 hours, and every 24 hours there after	Commander Approval

** Detainees must not remain in HCA for more than 24 hours without review, including a health review by the detention health service provider (DHSP).* ***Commander, National Immigration Detention (Operations) MUST review and make a decision on the recommendation for a detainee to remain in HCA after 72 hours, and then every 24 hours thereafter until the placement has concluded.***

All stakeholders must work together to move a detainee from HCA as soon as practicable.

Out of hours requests for DHSP advice on detainee placement in HCA should be requested from HAS line on 1800 197 659, and request that the advice be provided in writing to be attached as supporting documents. Officers should ensure advice on mental & physical health is sought including:

- any medication requirements whilst in HCA and
- any scheduled appointments onsite, offsite or via telehealth; these should be facilitated where appropriate.

The ABF Facility Detention Operations Superintendent and staff are to ensure that all records pertaining to the authorisation of initial and ongoing placement in HCA, including any email approval are recorded in Content Manager (formerly TRIM) with the relevant Content Manager file (TRIM file number) noted in the CCMD portal.

All record keeping associated with closer supervision and engagement of high-risk detainees and the use of HCA must be accurate, timely and complete.

Further guidance:

- *DSM – Detainee placement – Closer supervision and engagement of high risk detainees (High care accommodation) – PI (DM-626)*
- *DSM – Detainee placement – Closer supervision and engagement of high risk detainees (High care accommodation) – SOP (DM-3301).*

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HCA Decision - Choose an item.

Detainee Details					
Family Name:		Given Name/s:		DOB:	
Accommodation and Care Service ID:		SRAT Rating and date:			
Current IDF:		Current Placement:			
Is the detainee considered 'vulnerable'?	☐ No ☐ Yes ☐ minor ☐ risk of self-harm ☐ female ☐ elderly ☐physical or intellectual disability, condition or illness (including mental illness) ☐ gender-related special needs ☐has been subjected to psychological, emotional, physical or sexual violence or abuse ☐ English language abilities significantly impact the functional ability of the person in the circumstances ☐intoxicated/under the influence(suspected) ☐other (please specify) _____				

HCA Request Details			
Is the HCA placement voluntary or involuntary?	☐ Voluntary (**Note:** If voluntary, has the detainee made a request in writing? Refer to, *SOP (DM-3301)* for the *'Voluntary closer supervision and engagement form'* – Annex A) ☐ Yes ☐ No ☐ Involuntary		
Time and date of Incident triggering HCA placement *(if applicable)*	Date: Time:	CCMD IR: *(if applicable)*	OPTICS Ref: *(if applicable)*
Was Use of Force Required?	☐ No ☐ Yes (provide details)		
Initial HCA placement requested by:	Name: Position: Organisation: Date: Time:		

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Initial HCA request reasons: *(relevant documents must be attached, including DSP/Serco advice)*	Request should include details regarding: ☐ the detainee's wellbeing and level of care required ☐ the level and type of risks posed by the detainee ☐ the detainee's history of compliance whilst in detention ☐ the detainee's identified vulnerabilities, and ☐ the support and services which will assist the detainee.	
Planning:	☐ include clearly defined and reviewable milestones based on individual assessment ☐ identify the type and level of care required, including frequency of checks undertaken on detainee.	
Level of monitoring required during HCA placement?		
Conditions of HCA (eg, open door, access to programs and activities)		
How often will the detainee be engaged with?		
DHSP Advice (attach, or insert written advice) **Note - DHSP advice **must** be sought at least every 24 hours during HCA placement.*	Health advice includes: ☐ position/views on HCA ☐ advice on pre-existing health conditions ☐ advice on any medications ☐ detail of any scheduled appointments	
Where is the recommended HCA placement?	Location:	
When do you plan to commence HCA?	Date:	Time:
When do you plan to cease HCA?	Date:	Time:
Has a Behaviour Management Plan (BMP) been implemented and updated *(if applicable)?*	☐ Yes BMP reference number: _____ ☐ No (if no, why not?)	

HCA placement approved? (***Note**: A review is required **every 24 hours**)* ☐ Initial placement - Superintendent ☐ 24 hour review (up to 72 hours) – Superintendent ☐ 72 hours and every 24 hours thereafter – Commander approval	☐ Approved ☐ Declined Comments: Name: Position: ABF Commander Date: Time:
Have reasons for HCA placement been communicated to detainee?	☐ Yes ☐ No (if no, why not?)
Exit/Cessation of HCA	
Have the objectives of the placement been achieved? *Yes/No* Provide details:	
DHSP review obtained, confirming cessation of placement is appropriate? (Insert or attach advice) ***Note**: Include details of any additional supports required (if any) for reintegration*	
HCA cessation approved?	☐ Approved ☐ Declined, more information, or extension sought; Name: Position: ABF Detention Superintendent Comments: Name: Date: Time:
Time HCA placement ceased:	Date: / Time:

Australian Government
Department of Home Affairs

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Detention Services Manual – Detainee placement – Closer supervision and engagement of high risk detainees (high care accommodation)

Standard Operating Procedure

Document ID (PPN)	DM-3301
TRIM record number	ADD2018/5745877
BCS Function	Detention Management
Document owner	Chief Superintendent, Detention Governance, Strategy and Standards
Approval date	22 October 2021
Document Contact	Detention Operational Policy *detention.policy@abf.gov.au*

Table of Contents

1. Purpose

1.1. Introduction

1.1.1. This Standard Operating Procedure (SOP) outlines the operational procedure for undertaking closer supervision and engagement of high risk detainees in high care accommodation (HCA) and the associated record-keeping.

1.1.2. This SOP relates to and must be implemented in conjunction with *DSM – Detainee placement – Closer supervision and engagement of high risk detainees (high care accommodation) – PI (DM-626*).

2. Scope

2.1. In Scope

2.1.1. This SOP provides guidance to departmental officers and contracted service providers working in an immigration detention facility (IDF) regarding the procedures for:

- request and approval for placement under closer supervision and engagement
- implementing involuntary closer supervision and engagement
- implementing voluntary closer supervision and engagement
- record keeping and
- concluding closer supervision and engagement arrangements.

2.1.2. This SOP also includes the *Voluntary closer supervision and engagement placement form* – Annex A

2.2. Out of Scope

2.2.1. This SOP does not cover procedures in relation to:

- comprehensive processes for external arrangements of Tier 4 (Specialist Care Provider or Corrections) specific placements
- the use of specific infrastructure to accommodate high risk detainees
- initial placement of detainees; this is to be dealt with in accordance with:
    - *DSM – Detainee placement – Assessment and placement of detainees in IDFs – PI (DM-5126)* and
    - *DSM– Detainee placement – Detainee placement – SOP (DM-3248).*
- the placement of detainees in accommodation arrangements for health reasons such as medical and quarantine
- detainees separated for medical health reasons. However, all high risk detainees will be reviewed by the Health Services Manager (HSM) who will contribute to their management. For further information and guidance regarding health, contact:
    - *health@homeaffairs.gov.au* - for policy instructions and/or guidance
    - *detention.health@abf.gov.au* - for operational matters and

- *IDG.Healthcontracts@homeaffairs.gov.au* - for all onshore health services contract related matters, including Christmas Island.

3. Standard Operating Procedure

3.1. Request and approval for involuntary placement

Approving the involuntary placement of detainees under closer supervision and engagement

Step	Action	Person Responsible
3.1.1.	Report concerns and observations about the behaviour of a detainee to the ABF Detention Superintendent (Facility) or delegate.	FDSP Officer
3.1.2.	Request, in writing, placement of detainee under closer supervision and engagement, utilising the *High Care Accommodation Placement Template* – Annex A (refer to, *DSM – Detainee placement – Closer supervision and engagement of high risk detainees (high care accommodation) – PI (DM-626*) for the template). For urgent cases or in response to an incident or emergency, refer to **section 3.13** of *DSM – Detainee placement – Closer supervision and engagement of high risk detainees (high care accommodation) – PI (DM-626*).	FDSP Officer
3.1.3.	Assess the request to place a detainee under closer supervision and engagement. Consult detention health service provider (DHSP) on the physical and mental health of the detainee and appropriate observation intervals as required.	ABF Detention Superintendent (Facility) or delegate
3.1.4.	If the detainee under consideration is a non-citizen minor under the *Immigration Guardianship of Children* (IGOC) *Act 1946* (the IGOC Act), consult the IGOC delegate before making the placement decision. **Note:** Minors are detained only as a measure of last resort, for the shortest appropriate period of time and in the least restrictive form appropriate to a minor's circumstances. If a minor is accompanied by family members, the family unit must be maintained if possible; except in cases where it is contrary to the child's best interests.	ABF Detention Superintendent (Facility)
3.1.5.	On the advice of the DHSP, determine an appropriate period for placement under closer supervision and engagement.	ABF Detention Superintendent (Facility) or delegate
3.1.6.	Establish a clear plan for the detainee's placement under closer supervision and engagement, including a plan for the future cessation of the arrangement, in consultation with the relevant stakeholders. Use the *High Care Accommodation Placement* – Annex A (refer to, *DSM – Detainee placement – Closer supervision and engagement of high risk detainees (high care accommodation) – PI (DM-626*) for further information and the template) to record the decision.	ABF Detention Superintendent (Facility) or delegate

Step	Action	Person Responsible
3.1.7.	If closer supervision and engagement placement period **is less than 72 hours**, approve (or decline) placement in writing. **Note:** 24 hourly reviews are required up to the 72 hour time period.	ABF Detention Superintendent (Facility) or delegate
3.1.8	**If closer supervision and engagement placement extends beyond the initial 72 hours, seek approval from Commander, National Immigration Detention (Operations) in writing.** **Note: If closer supervision and engagement continues past 72 hours, Commander, National Immigration Detention (Operations) MUST review and make a decision on the recommendation for a detainee to remain under closer supervision and engagement each 24 hours until the placement is concluded.**	ABF Detention Superintendent (Facility) or delegate
3.1.9.	Contact the Facilities and Detainee Service Provider (FDSP) Facility Operations Manager (FOM) to advise whether detainee placement (and period) has been approved or declined.	ABF Detention Superintendent (Facility) or delegate
3.1.10.	Inform FDSP officer/s of approvals and actions associated with involuntary placement of detainee under closer supervision and engagement.	FDSP FOM
3.1.11.	Retain all information relevant to the decision taken on the placement of a detainee under closer supervision and engagement arrangement. Provide all the information to an ABF officer for recordkeeping.	ABF Detention Superintendent (Facility) or delegate
3.1.12	Ensure all information pertaining to the authorisation of the initial and ongoing placement of a detainee under closer supervision and engagement, including any approval email/s, is recorded in Content Manager (formerly TRIM) with the relevant Content Manager file (TRIM file number) noted in the CCMD portal. Refer to, *DSM – Detainee placement – Closer supervision and engagement of high risk detainees (high care accommodation) – PI (DM-626)* for further information and the template (*High Care Accommodation Placement* – Annex A).	ABF Officer
3.1.13.	If placement is declined, ensure all information including any email/s are recorded in Content Manager (formerly TRIM) with the relevant Content Manager file (TRIM file number) noted in the CCMD portal.	ABF Officer

3.2. Implementing involuntary closer supervision and engagement

Involuntarily relocating detainees into HCA as part of closer supervision and engagement arrangements

Step	Action	Person Responsible
3.2.1.	Undertake a risk assessment to determine how the detainee will be moved to HCA to undertake closer supervision and engagement arrangement.	FDSP officer

Step	Action	Person Responsible
3.2.2.	As part of the assessment, take into account Security Risk Assessment Tool (SRAT) data and current threat information.	FDSP officer
3.2.3.	Seek approval from the ABF Detention Superintendent (Facility) and advice from DHSP if planned use of force (UoF) is to be used. This may require submission of an operational plan or order. See: • *DSM– Safety and security management – Use of force – PI (DM-623)* and • *DSM – Safety and security management – Use of force – SOP (DM-3291).*	FDSP officer
3.2.4.	Ensure the planned UoF is recorded on video and audio, see: • *DSM – Safety and security management – Audio visual recording – PI (DM-614)* and • *DSM – SOP – Safety and security management – Audio visual recording – SOP (DM-3300).* Unplanned UoF must also be recorded where practicable.	FDSP officer
3.2.5.	If Emergency Response Team (ERT) are being engaged to transfer a detainee to HCA, ensure that body cameras are turned on for the duration of the transfer and retain the footage.	FDSP officer
3.2.6.	Transfer the detainee to HCA (onsite or at alternate IDF). If travel is required to transfer the detainee to HCA, care should be provided as soon as possible including during the transport and escort.	FDSP officer
3.2.7.	Commence closer supervision and engagement arrangement of the detainee.	FDSP officer
3.2.8.	Notify the DHSP when the detainee has been placed under closer supervision and engagement.	FDSP officer
3.2.9.	FDSP consider/confirm detainee observation intervals if placement relates to a psychological support program (PSP).	FDSP officer
3.2.10.	Update the accommodation status of the detainee on the CCMD portal within **four (4) hours**.	FDSP officer
3.2.11.	Review placement requirement upon expiration of placement period and action accordingly.	FDSP officer

3.3 Implementing voluntary closer supervision and engagement

Moving detainees into HCA to undertake closer supervision and engagement voluntarily

Step	Action	Person Responsible
3.3.1.	Any request by a detainee to voluntary be placed under closer supervision and engagement arrangement should be made in writing by the detainee using the *Voluntary closer supervision and engagement placement form* – Annex A.	FDSP or ABF Officer

Step	Action	Person Responsible
	If this is not possible, it must be recorded in writing by the ABF or FDSP officer to whom the detainee makes the request.	
3.3.2.	Discuss with the detainee reasons for requesting the voluntary placement.	FDSP Officer
3.3.3.	FDSP to consult with the DHSP on the appropriateness and suitability of closer supervision and engagement placement request.	FDSP Officer
3.3.4.	Engage DHSP to advise on the detainee observation intervals if FDSP considers frequent detainee observation is necessary. If any additional monitoring will be required, seek direction and approval from ABF Detention Superintendent (Facility).	FDSP Officer
3.3.5.	Complete the *Voluntary closer supervision and engagement placement form* – Annex A.	FDSP Officer
3.3.6.	Where a detainee cannot read, or language barriers are present, use an interpreter to complete the form or assist with the completion of the form (see *DSM – Communication and engagement – Interpreting and translating services – PI (DM-600).*	FDSP Officer
3.3.7.	In consultation with the detainee, add the reason for the requested placement.	FDSP Officer
3.3.8.	Ensure both the detainee and interpreter (where used) sign the request form.	FDSP Officer
3.3.9.	Submit a copy to the ABF Detention Superintendent (Facility) of the following for consideration: • the detainee signed *Voluntary closer supervision and engagement placement form* – Annex A, and • the *High Care Accommodation Placement* – Annex *A* (refer to, *DSM – Detainee placement – Closer supervision and engagement of high risk detainees (high care accommodation) – PI (DM-626*) for the template)	FDSP FOM
3.3.10.	Determine an appropriate period for voluntary placement under closer supervision and engagement arrangement. **Note:** If relocation is determined to be appropriate, it should only be for a short-term basis.	ABF Detention Superintendent (Facility) or delegate
3.3.11.	Approve (or decline) placement and inform FDSP FOM.	ABF Detention Superintendent (Facility) or delegate
3.3.12.	Retain all information relevant to the decision on the voluntary placement of the detainee under closer supervision and engagement arrangement. Provide all the information to an ABF officer for recordkeeping.	ABF Detention Superintendent (Facility) or delegate

Step	Action	Person Responsible
3.3.13.	Ensure all information pertaining to the authorisation of the voluntary placement of the detainee under closer supervision and engagement, including any approval email/s, is recorded in Content Manager (formerly TRIM) with the relevant Content Manager file (TRIM file number) noted in the CCMD portal.	ABF Officer
3.3.14.	If placement is declined, ensure all information including any email/s are recorded in Content Manager (formerly TRIM) with the relevant Content Manager file (TRIM file number) noted in the CCMD portal.	ABF Officer
3.3.15.	Transfer the detainee to HCA (onsite or at alternate IDF). If travel is required to transfer the detainee to HCA, care should be provided as soon as possible including during the transport and escort.	FDSP Officer
3.3.16.	Commence closer supervision and engagement of the detainee, as required.	FDSP Officer
3.3.17.	Notify the DHSP that the detainee has been voluntarily placed under closer supervision and engagement.	FDSP Officer
3.3.18.	Update the accommodation status of the detainee on the CCMD portal within **four (4) hours**.	FDSP Officer
3.3.19.	Review ongoing voluntary placement upon expiration of the placement period and action accordingly.	FDSP Officer

3.4 Supervision, engagement and record keeping

Engaging and monitoring detainees under closer supervision and engagement

Step	Action	Person Responsible
3.4.1.	Observe detainee at stipulated intervals: • for detainees on Behaviour Management Plan (BMP), as determined by FDSP (if necessary) • for detainees on PSP, as stipulated by DHSP For detainees in voluntary placement – as directed by the ABF in consultation with the DHSP. Consideration should be given to increase frequency of observation if the detainee is a minor.	FDSP officer
3.4.2.	If during observation, reasonable indication/s that a detainee's physical or mental health deteriorates is/are observed, arrange to have the detainee assessed by the DHSP immediately.	FDSP officer
3.4.3.	Upload all notes into CCMD Portal relating to observation of detainees under closer supervision and engagement.	FDSP officer

Step	Action	Person Responsible
3.4.4.	Assess the need for involuntary placements to remain under closer supervision and engagement every **24 hours**. Record actions and decision in CCMD portal. **Note: if closer supervision and engagement continues past the initial 72 hours, Commander, National Immigration Detention MUST review and make a decision on the recommendation for a detainee to remain under closer supervision and engagement each 24 hours thereafter until the placement is concluded.**	ABF Detention Superintendent (Facility) or delegate
3.4.5.	Assess the need for voluntary placements to remain under closer supervision and engagement at the expiration of the placement period. Consider detainee requests as appropriate. Record actions and decision in CCMD portal.	ABF Detention Superintendent (Facility) or delegate
3.4.6.	In the event of an incident resulting in a detainee placement under closer supervision and engagement, the incident must be recorded in OPTICS. Maintain incident logs for the duration of any ongoing incident. See: • *DSM – Safety and security management – Incident management and reporting – PI (DM-616)* and • *DSM– Safety and security management – Incident response and management – SOP (DM-3303).*	ABF Detention Inspector (Facility) and FDSP

3.5. Concluding closer supervision and engagement

Step	Action	Person Responsible
3.5.1.	Using the *High Care Accommodation Placement* – Annex *A* (refer to, *DSM – Detainee placement – Closer supervision and engagement of high risk detainees (high care accommodation) – PI (DM-626*) for the template), inform the ABF Detention Superintendent (Facility), of the reasons why it is no longer necessary for the detainee to be under closer supervision and engagement arrangement. Where the placement was voluntary, inform the ABF Detention Superintendent (Facility) of the detainee's desire to leave.	FDSP Officer
3.5.2.	For detainees on PSP, undertake a health assessment of the detainee. Advise FDSP if it is appropriate to remove detainee from closer supervision and engagement or recommend further period under closer supervision and engagement and appropriate observation intervals.	DHSP staff
3.5.3.	Consider the need for the detainee to remain under closer supervision and engagement arrangement from the information provided, steps **3.5.1.** and **3.5.2** refers.	ABF Detention Superintendent (Facility) or delegate

Step	Action	Person Responsible
3.5.4.	Inform FDSP of the decision to conclude the closer supervision and engagement arrangement.	ABF Detention Superintendent (Facility) or delegate
3.5.5.	Notify DHSP of impending release of detainee from closer supervision and engagement arrangement.	FDSP Officer
3.5.6.	Once the health assessment is complete, notify the ABF Detention Superintendent (Facility) that the detainee has been released from closer supervision and engagement or otherwise.	FDSP Officer
3.5.7.	Update the accommodation details of the detainee on the CCMD portal within **four (4) hours**.	FDSP Officer
3.5.8.	Finalise incident reporting (of closer supervision and engagement placement) in OPTICS (formerly BIMS/POMS) in accordance with: • *DSM – Safety and security management – Incident management and reporting – PI (DM-616)* and • *DSM– Safety and security management – Incident response and management – SOP (DM-3303).*	

4. Accountabilities and Responsibilities

Role	Description
Commander, National Immigration Detention (Operations)	Consider and make a decision on all closer supervision and engagement requests for detainees for the initial period of more than **72 hours** and approve the placement thereafter each **24 hours** until the placement is concluded.
ABF Detention Inspector (Facility)	Perform the responsibilities of the ABF Detention Superintendent (Facility) when on-call only.
ABF Duty Officer	The on-call ABF Duty Officer is responsible for approval of detainee placements under closer supervision and engagement in the absence of the ABF Detention Superintendent (Facility). Written approval from the ABF Detention Superintendent (Facility) can be provided retrospectively.
ABF Detention Superintendent (Facility)	• Decide and review voluntary and involuntary closer supervision and engagement placements every **24 hours**, up to **72 hours**. • Seek authorisation from Commander, National Immigration Detention (Operations) for involuntary and voluntary closer supervision and engagement placements that exceed **72 hours,** and then every **24 hours** thereafter. • Review voluntary and involuntary closer supervision and engagement placements upon expiration of the closer supervision and engagement period.

Role	Description
	• Approve planned use of force by the contracted service provider. • Maintain records of all closer supervision and engagement decisions and actions using the template *High Care Accommodation Placement* – Annex A.
Detention Health Service Provider	• Advise on the appropriateness of placing detainees in closer supervision and engagement placements. • Assess the need to enact supportive monitoring and engagement as part of the placement process. • Recommend appropriate detainee observation intervals depending on the circumstances of the placement and the mental health and wellbeing of the detainee. • Assess the health of detainees in closer supervision and engagement placements every **24 hours** and upon release.
Facilities and Detainee Service Provider	• Submit requests for closer supervision and engagement placements to the ABF Detention Superintendent (Facility). • Initiate the closer supervision and engagement process and actions associated with the placement as agreed by all stakeholders involved in the decision process. • Identify any concerns regarding the well-being of the detainee or the security and good order of the facility. • Engage with detainees and ensure their safety while in a closer supervision and engagement placement. • Monitor detainees in in accordance with agreed and specified detainee observation intervals. • Document observations and notify relevant stakeholders of changes in behaviour, positive or negative. • Seek approval for any planned use of force from the ABF Detention Superintendent (Facility). • Record the use of force on video and audio. • Make collaborative written recommendations to the ABF Detention Superintendent (Facility) regarding the exit from the closer supervision and engagement arrangement. • Release detainee/s from closer supervision and engagement placements when no longer necessary and as directed by the ABF Detention Superintendent (Facility).

5. Version Control

Version number	Date of issue	Author(s)	Brief description of change
2.0.	30/06/2017	Detention and Removal Operational Policy	Update of detention instructions to reflect PPCF requirements.
3.0.	20/11/2017	Detention and Removal Operational Policy	Reviewed as per Deputy Commissioner's request for 'extraordinary review'.
4.0.	10/09/2018	Detention and Removal Operational Policy	Update post legal review and Superintendent review.
5.0	22/10/2021	Detention Operational Policy	Updated with new timeframes for Commander approval. Inclusion of the Voluntary closer supervision and engagement placement form – Annex A PPCF mandatory three (3) year review. Updates made: • PPCF template • policy owner (section name) • terminology

Attachment A – Definitions

The terms and their accompanying definitions that have specific meanings in the context of the suite of detention instructions is at *DSM – Glossary – SM (DM-5249).*

Attachment B – Assurance and Control Matrix

1.1. Powers and Obligations

Please Note: Officers exercising any powers, delegations or authorisations outlined in this SOP (listed here) must check the latest delegation advice on the Intranet or the relevant instrument in LEGEND to ensure they currently hold the applicable power, delegation or authorisation.

Legislative Provision			Is this a delegable power?	If delegable, list the relevant instruments of delegation
Legislation	Reference (e.g. section)	Provision		
Australian Border Force Act 2015 (ABF Act)	subsections 44(3) and 45(3)	Disclosure of Immigration and Border Protection (IBP) information.	yes - authorisation	*Instrument of Delegation 2017* (DEL 17/082) (delegation applies to IBP workers of the Department of Home Affairs) *Australian Border Force (Secretary) No 1 of 2018 (ABF (s) No. 1 of 2018)* (delegation applies to IBP workers in the ABF) Authorisation to disclose Immigration and Border Protection information *DEL18/004* (Department of Home Affairs) Authorisation to disclose Immigration and Border Protection information - ADD2020/5712705 (applies to IBP workers of the ABF excluding OSB JATF)
	subsection 55(1)	The Secretary may, by writing, give directions to IBP workers in connection with the administration and control of the Department.	no	n/a
Immigration (Guardianship of Children) Act 1946)	subsection 5(1)	Delegation	yes	*Immigration (Guardianship of Children) Delegation (ADMIN 22/102) 2022*

Legislative Provision			Is this a delegable power?	If delegable, list the relevant instruments of delegation
Legislation	Reference (e.g. section)	Provision		
Migration Act 1958	paragraph 5(1)(g)	Definition of an officer	yes - authorisation	*Migration (Migration Officers) Authorisation 2021/001* (ADMIN21/001)
Privacy Act 1988	schedule 1	Australian Privacy Principles	no	n/a
Public Service Act 1999	section 13	APS Code of Conduct	no	n/a
Public Interest Disclosure Act 2013	section 7	Provides a means for protecting public officials from adverse consequences of disclosing information that, in the public interest, should be disclosed and provides for their investigation.	yes	Instrument 1 of 2020

1.2. Controls and Assurance

Related Policy	*DSM – Detainee placement – Closer supervision and engagement of high risk detainees (High care accommodation) – PI (DM-626)* *Records Management – PS (TI-1094)*
Procedures / Supporting Materials	*DSM – Detainee placement – Assessment and placement of detainees in IDFs – PI (DM-5126)* *DSM – Safety and security management - Audio visual recording – PI (DM-614)* *DSM – Communication and engagement – Interpreting and translating services – PI (DM-600)* *DSM – Safety and security management – Use of force – PI (DM-623)* *DSM – Safety and security management - Incident management and reporting – PI (DM-616)* *DSM– Safety and security management – Incident response and management – SOP (DM-3303)* *DSM – SOP – Detainee placement – Detainee placement – SOP (DM-3248)* *DSM – Safety and security management – Use of force – SOP (DM-3291)* *DSM – SOP – Safety and security management – Audio visual recording – SOP (DM-3300)* *DSM – Glossary – SM (DM-5249)*

Training/Certification or Accreditation	FDSP officer specific: (Use of force) Initial Training Course (ITC) – all FDSP officers Control Incident using Defensive Tactics (CSCSAS009) Psychometric testing Certificate II in Security (CPP20212) Control persons using empty hand techniques (CPPSEC3013A) Emergency Response Team (ERT) training – selected FDSP officers All FDSP officers undertake refresher training at least every two (2) years including reassessment to ensure their skills remain at the required level. Working with Vulnerable People registration
Other required job role requirements	Delegations Security clearance Departmental systems access
Other support mechanisms (e.g. who can provide further assistance in relation to any aspects of this instruction)	If you require further advice or assistance, or would like to provide feedback in relation to this SOP, please contact the Detention Operational Policy section at *detention.policy@abf.gov.au*.
Escalation arrangements	Escalation of concerns or issues regarding this SOP can be sent to Superintendent, Detention Operational Policy at *detention.policy@abf.gov.au*.
Recordkeeping (e.g. system based facilities to record decisions)	All records created as a result of this procedure must be managed in accordance with the *Records Management – PS (TI-1094)*. Records created as a result of this procedure must be saved in TRIM or an approved business system (i.e. CCMD, OPTICS, etc).
Program or Framework (i.e. overarching Policy Framework or Business Program)	Immigration Detention Facilities and Detainee Service Contract National and site-specific work instructions
Job Vocational Framework Role	Detention Operations – Job Code 30001731