NOTES ON HEALTH AND MENTAL HEALTH FOR ASYLUM SEEKERS AND REFUGEES HELD IN IMMIGRATION DETENTION CENTRES AND LIVING IN THE COMMUNITY

These notes are designed to give some idea of health and mental health issues affecting asylum seekers and refugees held in immigration detention centres and living in the community. They constitute a survey and review of some of the studies and reports touching on this subject.

It was originally prepared as a briefing note for the Federal Shadow Minister for Immigration.

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OVERVIEW

These notes are designed to provide information on health and mental health issues for asylum seekers in detention and in the community. Four main sections follow the overview, self-declaration and sources of information. The 4 sections are:

- What is Post traumatic stress disorder(PTSD) — detailed account
- Health & mental health for asylum seekers & refugees in detention
- Health & mental health for asylum seekers & refugees in community
- Federal/state relations, detention centre — alternative model

SPECIFIC APPLICATION

These notes apply to those people :

- In detention either because they are waiting the outcome of refugee status determination or have been deemed not to be refugees and are waiting deportation or are stateless and in limbo. The majority are boat people.
- In the community on Temporary Protection Visas (TPV's) or on various kinds of Bridging Visas.

The principles discussed regarding the need for proper health care apply to all people who arrived unauthorised whether by plane or boat.

The comments below need to be evaluated within the context of Australia's human rights obligations under the 1951 Refugee Convention and the 1967 Protocol[1]; the Convention on Civil and Political Rights[2] ; the Convention on the Rights of the Child[3] and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[4] and the Conventions on Statelessness[5]. There is evidence below which clearly demonstrate their violation. The recent Human Rights and Equal Opportunity Commission HREOC report on Children in Detention 'A Last Resort'[6] found that the Commonwealth's mandatory detention system contravenes its obligations under the Convention on the Rights of the Child. The report details individual provisions and provides evidence of their contravention. Amnesty International in its submission to this Inquiry has done likewise[7].

WHO IS A REFUGEE?

Australia is party to the 1951 Convention relating to the status of refugees and the updated 1967 Protocol. But the devil is in the detail. Two reports make one question why at least some of these people were not granted refugeee status. '*A Sanctuary under Review*', Senate Report, June 2000[8] ' and '*Deported to Danger*' Edmund Rice Centre et al. September 2004[9].

There are lots of reasons:

- Firstly to do with different interpretations eg at the Refugee Review Tribunal(RRT) level a large proportion of decisions by DIMIA at first instance are overturned.

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[1] 1951 Convention relating to the Status of Refugees & 1967 Protocol

[2] International Covenant on Civil & Political Rights 1976

[3] Convention on the Rights of the Child 1990

[4] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1987

[5] 1954 Convention relating to the Status of Stateless Persons & 1961 Convention on the Reduction of Statelessness

[6] Human Rights & Equal Opportunity Commission, '*A Last Resort*'. National Inquiry into Children in Immigration Detention. April 2004. In this paper will be referred to as the HREOC Inquiry.

[7] Amnesty International Submission to the HREOC Inquiry. See under 'Health Concerns' pp5-8

[8] Senate Legal & Constitutional References Committee, '*A Sanctuary under Review*', An Examination of Australia's Refugee & Humanitarian Determination Processes. June 2000, Chapters 2,7,9 & 11

[9] '*Deported to Danger*', A Study of Australia's Treatment of 40 Rejected Asylum Seekers. September 2004. A Project of the Edmund Rice Centre for Justice & Community Education in cooperation with the School of Education, Australian Catholic University.

- Secondly the presumption for boat people is that they are here illegally and the applicant has to prove otherwise which reverses the onus of proof in most civil litigation.
- Thirdly there is the narrowing of the Migration Act, eg. *The Migration Legislation Amendment Act 2001*(comm) section 5 has narrowed the definition of persecution which of course affects policy and procedure further down the line.
- Fourthly the sovereign government will ultimately decide the parameters of the definition to fit within their philosophy.

The Edmund Rice Report explains that the 1951 Convention's definition of refugee does not include all the categories of people in need of international protection. It does not, for instance, extend to the needs of people who are stateless, whose country is in a state of civil war; whose human rights have been violated for non-Convention reasons; who would face torture on return; whose country is one where the rule of law no longer applies[10]. To meet the protection needs of such people several European countries have introduced a separate visa category called Complementary Protection. Addressing the same issue in the Australian context, in January 2004 the Refugee Council, the National Council of Churches and Amnesty International produced a new model for assessment of protection applications[11]. **The model includes both Refugee Status and Complementary Protection in each stage of the assessment process.** The model would remedy some of the well documented deficiencies of the present system.

PLATFORMS AND POLICIES OF THE COALITION, LABOR, DEMOCRATS, GREENS AND FAMILY FIRST

Border Protection

Border protection is stressed by the Coalition, Labor and Family First.

The Pacific solution is Coalition policy, 'we will retain the policies of excision, offshore processing and mandatory detention that have acted as a powerful deterrent to illegal immigration'.

Labor would continue excision of Christmas Island, Cocos(Keeling) Islands and Ashmore reef from Australia's migration zone and support the building of the Christmas Island Immigration Detention Centre. Such centres would be run by the public sector.

The Democrats and the Greens are totally opposed to mandatory detention, excision and off-shore processing.

Human Rights

The Democrats and the Greens stress Australia's human rights obligation under a variety of International treaties and the absolute necessity of honouring them.

Labor's platform as distinct from its policy gives commitment to human rights conventions and treaties.

The Coalition's platform mentions providing a 'safe haven for refugees and the promotion of human rights' .[12]

[10] 'Deported to Danger' P 41 Ref 9

[11] RCOA, NCCA, AI, 'Complementary Protection -The Way Ahead', January 2004

[12] Coalition platform, p21

Family First refers to 'fairness', 'justice' and 'compassion' in relation to refugees.

Detention

Labor instituted mandatory detention which they would retain but for no longer than 90 days for 90% of applicants (and their children) for health and security checks. Placement in a supervised hostel would follow. Both these stages would most likely occur on Christmas Island unless a regional group applies to run such a facility in their area. Children would attend local schools. There would be a monthy review of asylum seekers held beyond this period. Labor believes there is no place for the long-term detention of children.

Family First speaks of a strictly limited period of detention only for the purposes of health and security checks.

The Democrats and the Greens are against detention of any kind but acknowledge the need for health and security checks which would take place within a 'facility' or reception centre. Children are not to be held there for more than a few days.

Unaccompanied minors are specifically mentioned by the Democrats and Family First as requiring foster care arrangements not detention.

Labor would appoint a Childrens Commissioner as guardian for such children.

The Greens spell out the Convention of the Rights of the Child and its implications for the care of children and minors.

The Democrats acknowledge the need for a short-term detention facillity for visa overstayers and criminal deportees about to leave the country but stress that it should be located in a major capital city. The Democrats moved changes to the Migration Act to end mandatory detention and in 2004 to ensure that children could not be detained for more than 12 weeks.

Independent Monitoring of Detention Centres & Role of Judicial Process

Labor proposes independent medical practitioners with freedom to report conditions in detention centres, access by the press and the appointment of an Inspector of Detention. The Independent Review Committee to deal with outstanding applications is not spelt out. The RRT would be replaced by a similar body with three members, chaired by a person who is legally qualified.

The Democrats are concerned about appeals from RRT only allowed on a point of law rather than on the merits of a Tribunal decision. They want an amendment to the Migration Act so that families cannot be deported. without being able to appeal the matter, especially in those cases where the families have lived for years in Australia. They want reception centres to be in urban areas.

The Greens want immediate legal aid assistance to newly arrived refugees and with unrestricted entry and exit to detention centres.

Labor, Democrats, Greens and Family First want to see a greater degree of fairness and thoroughness in the applicant assessment at first instance.

Both Democrats and Greens reject the seven and forty-five day rules which disadvantage asylum seekers chances of ever being assessed as refugees.

Convention Definition of Refugee and Those Requiring Humanitarian Assistance Outside its Ambit

The Greens recognise Australia's narrowing of the interpretation of the the Refugee Convention.

Labor, Democrats and Greens mention increasing the humanitarian visa category.

The Democrats and Greens want an expanded refugee intake in the words of the Greens, 'that more equably reflects Australia's share of international responsibility'.

Labor wants to set in train a 'one world' refugee processing system for refugee claims to enhance equable treatment of applications between one country and another.

Funding Assistance to Other Countries

Labor, Democrats, Greens and Family First recommend more humanitarian aid to poorer countries.

The Greens put it this way, 'the expansion and improvement of international programs to address migration issues and the global crisis in human movement'.

Labor would increase funding to UNHCR to assist those currently living in refugee camps.

Access to Resources by Asylum Seekers and Refugees in the Community

It involves access to financial support, medicare, housing, legal aid, interpreters, education, Migrant Resource Centres, language programs and with the right to work.

Access is promoted by the Democrats and the Greens.

Family First supports access to a limited extent.

Labor will allow TPV holders to access settlement services including English language training and the job network and is reviewing policies during 2005.

Current bridging visa holders have a variety of entitlements. Some are entitled to work and medicare if they meet the 45 day rule. A small group is eligible for the Asylum Seeker Assistance Scheme payment through Red Cross. But many have no right to work, medicare or any welfare payment. In March 2005 the Government announced the Removal Pending Bridging Visa; granted if asylum seekers have exhausted their appeal rights, are prepared to forego any further legal action to remain in Australia and agree to voluntarily return to their country of origin when feasible. This group is given access to medical benefits, work rights and some social security benefits. Only a few long term detainees will benefit from this type of visa.

Temporary Protection Visas

Both Labor and Family First support a period of two years on a TPV before being eligible for permanent refugee status. For Labor refugee status provides eligibility for family reunion though priority will be given to those who have settled in the regions of Australian designated as in need of population and with labour shortages.

This contrasts with the Democrats and Greens who once an asylum seeker was judged a refugee would give permanent status with the right to family reunion.

Deportation

The emphasis placed on Human Rights and International treaty obligations by the Democrats and the Greens in their policies covers this area. The Refugee Convention and the Convention Against Torture contain the non-refoulment provisions, overlapping to some degree.[13]

Both Labor and Family First stress the need to process applications for refugee status quickly and expeditiously, a two edged sword as it could mean too quickly for a fair and just assessment so that deportation could be expedited, or quickly at first instance to get the asylum seekers out of detention to allow more thorough work to follow.

Labor is committed to monitoring the return of failed asylum seekers through an agency like the International Red Cross.

The Government is regularly deporting asylum seekers who do not fit within their interpretation of the Refugee Convention. The Senate Legal and Constitutional References Committee in 2000, *'A Sanctuary Under Review' t*he Edmund Rice Centres Report in 2004, 'Deported to Danger' describe this policy and the apparent disregard for the deportees safety, human rights and care for their future.

Call for Independent Public Judicial Review (and For Some A Royal Commission) Into the Government's Asylum Seeker and Refugee Policy

For some parties this push was precipitated by the Cornelia Rau and Vivian Solon cases.

Some of the Governments own back benchers are uncomfortable with the non-public nature of the Palmer Inquiry and are highly critical of the current immigration detention policy.

Federal Labor is now calling for a Royal Commission. In early May the Immigration Ministers Council comprising the Labor States called for the release of all children from Immigration Detention, for a Royal Commission into treatment of refugees and for an amnesty for all TPV holders to claim permanent residency.

The Greens have always demanded a Royal Commission on those issues which arise over immigration detention, deportation and human rights issues.

The Democrats want a Royal Commission on mismanagement by Immigration Department.

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13 The UNHCR' s Executive Committee cautions the States that an asylum seeker not accepted by that country and to be returned to country of origin sending back an asylum seeker must ensure that the need for international protection has in fact ended. The State needs to check also that there are no other compelling reasons why a person should not be returned, eg.severely traumatized persons should not be forced to return to their country of origin. (UNHR 'Refugee Protection' A Guide to International Refugee Law, 2001).

UNIVERSAL CONDEMNATION OF DETENTION POLICY

The unanimous verdict of almost all European governments, the UNHCR and other human rights, medical and health organisations in all parts of the world is universal condemnation of long-term and indeterminate detention policy. For those who pose a security or health risk their stay in detention should be reviewed by a court on a monthly basis and there should be public, media and legal access throughout their detention.

EVIDENCE

There is incontrovertible evidence that indeterminate detention and detention for long periods damages people irreparably in body, speech and mind. The severe health and mental health problems of asylum seekers is as much a reaction to the conditions of indeterminate detention as it is the original traumatic stressors which occurred in their home countries or en route to Australia.

EFFECTS OF INDEFINITE DETENTION

Initially people locked up having committed no crime feel a deep sense of injustice. If over time this injustice is not righted there is a growing loss of hope, gradual onset of depression into its destructive forms of deep rage and resentment and ultimately in many cases an irreversible decomposition of the personality. To our shame as a country there are real examples of people who have deteriorated to the point of no return in detention, in psychiatric hospitals and in the community. There are others who have been rendered helpless and incompetent as husbands, wives and parents through this regime. Whether asylum seekers are eventually let out or are deported back to their home country, it is both inhumane and dangerous to damage people in this manner and cause destruction of their core values through engendering bitter thoughts of self destruction or revenge. How can we allow this to happen in Australia of all places!

SHORT-TERM DETENTION

Other countries do not detain asylum seekers for indefinite periods and most do not hold children for more than a few days. Detention is used for security and health checks. During the processing phase asylum seekers are placed in a variety of community settings. Short-term detention for health and security checks can be carried out in secure facilities but these should be in urban areas available to scrutiny by the public, the media, parliamentarians, legal and health professionals. They need to be places filled with activities engendering fun, exercise, learning, skills development and enhance relationships within families and groups. The staffing needs to be diverse and highly trained in the helping, healing, language,recreational , teaching, interpretating and translation professions. Security issues needs to be reasonable and transparent to detainees with rights of complaint and appeal when incidents occur. A Case manager should be available to each asylum seekers with regular meeting times available with access to their lawyer to see their application for asylum through to the end point.

SWEDISH EXPERIENCE SIMILAR TO OUR OWN[14]

Much of the above description is drawn from Sweden's experience. This country went through hunger strikes, breakouts, riots with detainees. Sweden learned from the experience and placed their Detention Centres under direct government control and not with private companies. They changed their policies and procedures to the sensible and workable system it is today. **By law no child is held in detention for more than 6 days**. Their system is not a push-over but does not breach human rights and has built in a variety of supports for refugees and staff involving information exchange and conflict resolution.

DIFFERENCES BETWEEN ONSHORE REFUGEES AND OFFSHORE ASYLUM SEEKERS

Those who come by boat may have similar backgrounds to off shore humanitarian visa holders through UNHCR. But one study did find that detainees may have suffered greater levels of threat and trauma than other refugees. This suggests that those under most threat tend to leave their home countries in haste, often without documents(Thompson & McGorry,1998 in *Silove & Steel*)[15].

The essential difference is that on-shore aylum seekers in Australia are mostly held in detention for long periods until their applications are fully processed. If rejected for refugee status they remain in detention. If accorded refugee status they are released into the community on Temporary Protection Visas(TPV's) without security of status (they could ultimately be sent back to their country of origin if the government deems conditions to have sufficiently improved). Those in the community on different forms of bridging visa are also living with continual uncertainty. This contrast is important because in terms of health care provision we are dealing with a different set of problems. **Uncertain status as a factor in itself is likely to lead to poor health outcomes**(Becker & Silove 2001)[16].

NEED FOR ACCESSIBLE HEALTH SERVICES

Access to free health services, government benefits, accommodation and schools is essential. This initial investment will pay dividends. These people will be able to contribute to the economy and to the social and cultural capital of this country. Health services need to be predictable and reliable with access to interpreters and with the capacity to develop a relationship of trust with the health care provider. Many ordinary and unique health problems emerge in refugee populations. They need to be treated immediately and over time. The relationship is a bridge whereby the refugee patient can trust the practitioner sufficiently to reveal difficult and embarassing health problems, such as sexually transmitted diseases. An added bonus would be health practitioners who can recognise and treat post traumatic stress disorder(PTSD) in an individual and family context and differentiate these symptoms from the garden variety health problems. Under these circumstances the condition of PTSD as an underpinning condition of many health and mental health problems can be addressed over time.

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[14] Submission to HREOC Inquiry by Professional Alliance for the Health of Asylum Seekers and their children. pp50-53

[15] Thompson M, McGorry P. Maribyrnong Detention Centre Tamil Survey.1998 In Silove D, Steel Z, eds. *The Mental Health & Well-being of Onshore Asylum Seekers in Australia*, Sydney: University of NSW, Psychiatry Research & Teaching Unit. 1998:27-31 taken from MJA 2001; 175:596-599.

[16] Becker R, Silove D. Psychiatric & Psychosocial effects of prolonged detention on Asylum Seekers in Crock M, ed. *'Protection or Punishment: the detention of Asylum Seekers in Australia*. Sydney: The Federation Press, 1993 in MJA 2001;175:596-599.

COMPLEMENTARY PROTECTION

Consideration needs to be given to introducing a separate visa category called Complementary Protection, an option which the European Union is in the process of adopting. This would meet the protection needs of people who are stateless, whose country is in a state of civil war, whose human rights have been violated for non-Convention reasons, who would face torture on return; whose country is one where the rule of law no longer applies. This would circumvent the damaging processes which occur currently to hundreds of detainees and may do so in the future. At a time when the economy is short of skilled labor and is considering the entry of guest workers, the asylum seekers freed up by this consideration would make a great contribution to the economy and to Australia. Such an approach would have the effect of stopping the crisis- ridden approach to asylum seekers. Most recently Neill Wright regional representative of the UNHCR has stepped in to ask the Howard government to find a humanitarian solution for more than 54 desperate asylum seekers holed up in Nauru whom he describes as being 'between a rock and a hard place'. He adds, '**it is probably the uncertainty more than anything else that is damaging for their mental health'** (*Age* 18/4/05)[17].

WHAT IS POST TRAUMATIC STRESS DISORDER(PTSD)?

Post Traumatic Stress Disorder is likely to be a factor to be reckoned with amongst many refugees. Therefore it is important that its pervasive effects are understood upfront.

Definition

PTSD is a total physiological response of the body to experiencing, witnessing or being confronted with an event or events that involved actual or threatened death or serious injury resulting in intense fear, helplessness or horror. The event is persistently reexperienced day or night leading to avoidance of reminders of the trauma, disengagement, sleep disruption, extreme startle response; alternating with irritability, sometimes blind rage, frustration and utter despair.

Prevalence

As will become clearer from the research presented on Post Traumatic Stress Disorder (PTSD) this condition is prevalent in refugee populations ranging from up to 80% to as low as 12% depending on current circumstances. Life time prevalence in trauma surgvivors is generally 23.6% (Kessler et al.1995)[18].

PTSD Common Amongst Refugees Populations

This response is endemic in traumatised refugee populations in all parts of the world where war and conflict is rife and torture and mass killings are frequent

[17] *The Age* 18/4/05 p1

[18] Kessler RC,etal(1995) Posttraumatic stress disorder in the National Comorbidity Survey in *Archives of General Psychiatry* 52;1048-1060

Mitigation Factors

Reactions or symptoms of this disorder is shown to be mediated by a sense of safety, security, certainty and social support in the host country. If conditions do not allow such an environment, the frightening symptoms of PTSD do not diminish but can become entrenched.

PTSD in Children

For children with PTSD the condition is lessened when parents are able to provide for their needs in terms of protection, nurturing, and with the capacity to convey a belief in the future. When parents are demoralised by continuous incarceration with no end point they are not able to provide this care. Under such circumstances children are left to fend for themselves or in some instances take over the parenting function for younger siblings. They are more vulnerable to abuse, rape and unsavoury experiences with guards, caretakers and strangers which further exacerbates their symptoms and underlying disorder(Sultan & O'Sullivan 2001)[19]. PTSD is a common outcome for most children reared in detention centres for long periods(Mares and Jureidini 2002)[20] .For parents on TPV's, poor social support, low-income and unable to plan a future they find it difficult to provide a good environment for their children.

PTSD Made Worse by Uncertainty

PTSD is exacerbated by uncertainty. In fact it can only be treated when two sets of conditions apply :

- basic human needs are met such as income to pay for food and accommodation.
- a feeling of safety, security and certainty permeates the atmosphere. at home, school and work(Herman, J.1992)[21].

Differences Between TPV/Bridging Visa holders and UNHCR Humanitarian Visa Holders In Terms of Health Outcomes

The UNHCR Humanitarian visa group however much affected by PTSD are helped to settle and attain the minimum requirements for attending to their health and PTSD condition. The TPV/ Bridging Vis holders have no security and after August 2004 are barred from applying for a permanent visa. They cannot settle and plan for the future. So these potentially similar groups in terms of background diverge markedly when it comes to predictable health outcomes.

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[19] Sultan, Aamer & O'Sullivan, Kevin. Psychological Disturbances in Asylum Seekers held in long term Detention: A participant observer account. *MJA* 2001;175:593-596

[20] Dr Sarah Mares & Dr Jon Jureidini. Children and Families Referred from a Remote Immigration Detention Centre paper presented at '*Forgotten Rights, Responding to the Crisis of Asylum Seeder Health Care*' A National Summit, NSW Parliament House 12/11/03

[21] Herman, J. *Trauma and Recovery* Basic Books, 1992

SOURCE OF INFORMATION IN BROAD CATEGORIES

- International human rights conventions to which Australia is a signatory
- Labor Party Policy on asylum seekers and refugees
- Parliamentary Reports such as the Subcommittee on Human Rights, Joint Committee of Foreign Affairs, Defence and Trade
- Submissions to relevant Inquiries eg HREOC 2003;1999;1998
- War and Veteran research literature
- Refugee research literature
- Web pages AMA; ANF; RAPC; RANZCP, APS and Amnesty Australia
- Reports from National Centre for war-related Post Traumatic Stress Disorder,
- Medical Association for the Prevention of War (MAPW), Edmund Rice Centre, Australian Refugee Rights Alliance, Human Rights Council of Australia.
- Journals (detailed in the references) in the areas of:medical, nursing, behavioural therapy, family therapy, family networks, social psychiatry, psychiatry, child and adolescent psychiatry, child psychiatry, biological psychiatry. trauma and stress, anxiety disorders, nervous and mental disease,
- Annual Reports and reports from institutional sources,eg Commonwealth Ombudsman, Surveys.
- Individual and group accounts drawn from Inquiry submissions.
- Hansard record of questions, speeches and interchanges.
- Speeches by parliamentarians.
- Articles on refugee matters
- Refugee websites Information drawn from; RAC, Chilout, Rural Australians for Refugees, Australians against Racism et al.
- Herman, Judith. *'Trauma and Recovery'* Basic Books, NY 1992

Academic, Clinical and Research Psychiatrists and Psychologists

The research from which some of the evidence is drawn has been rejected by the federal government. because of alleged bias. This issue has to be spelt out clearly otherwise the reputation of the psychiatrists who have made representations to government about the mental health of detainees will be impuned and rendered irrelevant. Their views are based on hard evidence from research, their clinical practices and their professional and research networks across the world who share their conclusions. They are 100% supported by the AMA, ANF, RACP, RACGP, RANZCP and the APS to identify a few health professional groups(Appendix 1) and all members of the Professional Alliance for the health of Asylum Seekers and their Children (Appendix 3*)* They are against long-term detention. They would not support children being held in detention for more that a few days.

Evidence Based

They are against the government's policy of detention due to overwhelming evidence that indefinite detention maintains and increases mental illness. Under such circumstances no appropritate treatment is possible because the environment is the problem. They have observed the health and mental health effects on adult and children detainees for themselves which they distinguish from the legacy of psychological and psychiatric difficulties which many refugees brought with them as a result of torture and trauma in their countries of origin. They have observed the debilitation and deterioration of the detainees worsening over time. Now Dr. Howard Gorton former psychiatrist in 'Baxter has come out supporting these psychiatrists.

> 'The people I saw and treated in Baxter were **the most damaged people I've seen in my whole psychiatric caree**r. Up until that time, I'd never met an adult onset bed wetter. I'd never met someone with psychological blindness. And there were also a few physically crippled people who believed they were unable to walk, and this was probably psychological too'.(Four Corners ABC 5/4/05)

The HREOC Inquiry Report Draws the Evidence Together

These psychiatrists and psychologists contributed to the HREOC Inquiry and made the point that children and their families who are psychiatrically unwell cannot be treated within the detention centre environment because the environment is one of the major causes of the problems[22] A psychologist who worked at Woomera told the enquiry

> 'I was working in a no win environment because I couldn't change the environment. No matter how much I worked with the clients, I couldn't change the cause of their behaviour, the cause of their stress. It's like having a patient come into the hospital with a nail through the hand and you are giving pethedine injections for the pain but you don't remove the nail. That's exactly what is happening in Woomera. You've got people down there with nails through their hands, we're holding them. we're not treating the cause. So the trauma, the torture, the infection is growing. We're not treating it—we're just containing it. Eventually when those people return to their homelands. if they don't get temporary visas, they are going to carry that with them)[23]

An early report by Mares and Newman forms the basis for their early professional judgment and is a vivid account of the harm accruing to children of the detention environment(Mares,S. Newman L. et al. 2002)[24].

The Minister for Immigration Seeks Other Advice

The Minister for Immigration, Senator Vanstone is on record as having funded a $30,000 report to refute these findings(Parlinfo web 15/2/2005)[25]. This is a waste of tax payers money and another dangerous attempt to deny the obvious.

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[22] HREOC Inquiry p423

[23] Harold Bilboe. Transcript of Evidence to HREOC Inquiry. Sydney 16/7/02, p423

[24] Mares, Sarah; Newman, Louise; Dudley, Michael; Gail, Fran. Seeking refuge, losing hope: parents and children in immigration detention. Australian Psychiatry, Vol. 10, No 2. June 2002

[25] Parliament of Australia. parlinfoweb.aph.gov.au 26/3/05 for statement on 12/2/05

DECLARATION OF BACKGROUND & INTEREST

Rosemary Nairn was a counsellor for 5 years in Vietnam Veterans Counselling Service Canberra working with veterans with post traumatic stress disorder. She was director of the Canberra Child and Adolescent Unit for three and a half years working with psychiatric and behavioural problems. Rosemary is currently a member of RAC in the ACT, and previously a member of the Darwin Health Refugee network.

PLAN FOR THE REST OF THE PAPER

The notes are divided into four main sections:

- Post traumatic stress disorder (description & current examples)
- Health of asylum seekers & refugees **in detention centres**
- Health of asylum seekers & refugees **in the community**
- Federal/state relations & detention centre alternative model

POST TRAUMATIC STRESS DISORDER (PTSD)

How is an understanding of PTSD important in dealing with health problems and health services for refugee populations?

What It Is Not

PTSD was still a novel and largely unknown diagnosis in the early 90's. A decade later it takes on new connotations as the acronym is used in relation to any stressor which is upsetting. It has been applied erroneously to the mishaps of day-to-day life. 'Stress' as a cause of illness is a cliché of the modern press. However as McFarlane 1989[26]explain

> 'misuse of a paradigm is a reflection on the individuals responsible, not on the paradigm itself'.

What It Is

Basically PTSD is a constellation of symptoms arising from experiencing a terrible event(s) where the person perceived themselves or someone connected with them as threatened with immediate death or injury and involved great fear, terror or a sense of helplessness. Professor Judith Herman in *'Trauma and Recovery'*1992[27] describes PTSD succinctly and eloquently.

> 'Trauma destroys the social systems of care, protection and meaning that support human life'

In PTSD neurophysiological changes take place in the brain and body underpinning the cycling emergence of hypervigilance, avoidance, thought intrusion, numbing, disassociation and a variety of somatic symptoms.(McFarlane et al 1997[28]; Charney, Deutch et al1993)[29]

Complex PTSD

Complex PTSD can be distinguised from a more 'straightforward' 'simple' PTSD outcome arising from a single event. Complex PTSD often involves predisposing conditions such as vulnerabity to depression, childhood abuse and such like. Professor Judith Herman 1992[30] describes a set of symptom groups. These more accurately reflect the complex post trauma conditions observed in asylum seekers in detention including those who have been tortured(McIver & Turner)[31]. They tackle the multiple external traumas of such severity that at least 60% of a population would be affected by the condition.eg survivors of Pol Pot regime in Cambodia.

Factors Influencing the Severity of Reactions

A post trauma condition does not happen to everyone. Some people are more vulnerable: for example prior psychiatric history, pre-existing tendency to anxiety or depression, substance dependence; childhood abuse, family dysfunction.or genetic vulnerability(Creamer et al.1994)[32], (Gibbs,1989)[33].

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[26] McFarlane,A.C.(1989) The Aetiology of Post-traumatic Morbidity: Predisposing, Precipitating and Perpertuating Factors. British Journal of Psychiatry 154; 221–228

[27] Herman, Judith.'*Trauma and Recovery*' Basic Books, 1992, NY

[28] McFarlane, Alexander C. Traumatic Stress Disorder: the importance of clinical activity & systematic research. *Medical Journal of Australia* vol.166 20/1/97

[29] Charney, D.S. Deutch, A.Y.et al.1993. Psychobiologic mechanisms of posttraumatic stress disorder. *Archives of General Psychiatry*, 50, 294-305

[30] Herman, Judith.'*Trauma and Recovery*' Basic Books, 1992, NY

[31] McIver, Turner et al.1995, Assessment & treatment approaches for survivors of torture. *British Journal of Psychiatry*, June Vol 166(6) 705–71.

[32] Creamer, M.1994 Community recovery from Trauma in R. Watts & D. Horne eds *Coping with Traumas the Victim and the Helper* Brisbane, Australian Academic Press pp37–52

[33] Gibbs,M.S. 1989 Factors in the victim that mediate between disaster and psychopathology: a review, *Journal of Traumatic Stress*, 2. 489–514

The trauma experience itself will vary in its effects according the degree of life threat, duration and severity of the event, whether this happened alone or with other members of family or community and level of displacement from their community(Wilson & Raphae1993[34].

The Event Itself

It could be one awful event perceived as life -threatening or a series of overwhelming events.

The Post-Event Experience

The recovery environment seems to be critical; that is, even people who experience severe trauma can recover well if the environment is conducive. Herman 1992[35] describes the recovery process.

> 'The essential features of the trauma are disempowerment and disconnection from others. The recovery process, therefore, is based upon empowerment of the victim and the creation of new connections. The recovery process, like the trauma itself, is inseparable from its social and political context'.

PTSD — A Simple Description

> 'People with PTSD complain of amost unbearable states of physiological arousal: a hypersensitive emotional tripwire, an exaggerated startle response and profound distortions of memory. In paradoxical oscillating fashion, sleeplessness and hypervigilance alternates with numbness and withdrawal, amnesia cooexists with flashbacks. These wildly swinging inner states make people feel helpless—they fear thay are going crazy and sense that they're not the same person they used to be (Vietnam Veterans with PTSD fit this description.Their wives describe their husbands as changed in personality from what they were before they had the condition). This in turn can set off a cascade of negative effects, disrupting relationships and driving people to self-medicate with alcohol and drugs'(The Family Therapy Networker US 1996.[36]

PTSD in Children

Unless one understands the context and the profile of PTSD it is easy to overlook the impact on children. But when one talks to health care providers working across detention centres the story is always the same. Children are showing severe signs of psychological disturbance from failure to thrive in babies and infants, to bed wetting, night terrors, and withdrawal from the external environment and self harming and suicidal behaviour in adolescents. Severe attachment disorder has been documented in young children and those born in detention.(Silove; Steel et al.)[37] In a study undertaken on children and families referred from a remote detention centre children under 5 were showing cognitive impairment, disturbed sleep and feeding routines and parents said they didn't know how to play and no longer obeyed them. Disturbances of attachment were showing, highly correlated with exposure to violence and chronic parental mental illness. For children between 6 and 17 years all of the 10 children studied fulfilled criteria of PTSD. All the older children reported graphic intrusive memories and thoughts of adults self harming. They had all witnessed attempted hangings, slashings and self-poisoniing. All the sample reported

[34] Wilson, J.P.& Raphael,B. 1993. *The International Handbook of Traumatic Stress Syndromes* Plenum Press NY.

[35] Herman, Judith *Trauma and Recovery*'1992 Basic Books, N,Y

[36] The Family Therapy Networker US 1996 July/August p40

[37] Silove,D; Steele,Z; Mollica,R 2001. Detention of asylum seekers: assault on health, human rights and social development. *Lancet* 2001;357:1438-1437

trouble sleeping, poor concentration, little motivation for reading or study, a sense of futility and hopelessness and overwhelming boredon. All reported recurrent thoughts of self harm.(Mares & Jureidini 2003)[38].

PTSD in Children Sometimes Unnoticed by Traumatised Parents

Distressed parents often underrate their childrens symptoms(Almqvist & Bromberg 1999[39] Geltman et al 2000[40]) In another study comparing parental and child assessments the authors commented that parents did not report their child's fatigue, palpitation,breathing problems, trembling or crying, reinforcing the importance of attaining data directly from children.(Kocijah-Hercigonja et al 1998)[41].

Parents Deroled in Detention Environment

Severe disturbance in children is made worse by the fact when their parents have been deroled in the detention environment, are mostly depressed and are thus rendered ineffective in providing their children safety, protection and security. In the community they face the struggle of endeavouring to meet basic needs such as food and shelter.

[38] Mares,S & Jureidini,J.2003 Children & Families referred from a remote Immigration Detention Centre. Paper presented at *'Forgotten Rights- Responding to the Crisis of Asylum Seeker Health Care, A National Summit*, NSW Parliament House, 12/11/02

[39] Almqvist,K & Broberg, A.G. 1999 Mental Health & social adjustment in young refugee children years after their arrival in Sweden. *Journal of the American Academy of Child & Adolescent Psychiatry*, 38 (6), 723-730

[40] Geltman, P.L. et al.2000 War trauma experience and behavioural screening of Bosnian refugee children resettled in Massachusetts. *Journal of Developmental & Behavioural Pediatrics*, 21(4):255-261

[41] Kocijan-Hercigonja, D et al.1998 Mental health condition &adjustment of refugees & displaced children in a war area. *Psychiatria Danumina* No(1):23-29

PTSD AND OTHER MENTAL HEALTH DISORDERS

PTSD can be isolated from but can co-exist with other physical and mental disorders. It is often compared with **'acute stress disorder'** but is identified quite separately in the DSM IV American Psychiatric Classification because of the markedly different symptoms and timing. **'major depressive disorder'**(MDD) and **'generalised anxiety disorder'**(GAD) are readily distinguised from PTSD by clinicians **but are frequently associated with the condition** (Bleich et al.1997[42] Keane et al[43]).

The Escalating Features in Depression Correlated With Increasing Time in a Detention Centre Awaiting a Decision On Refugee Status

Sultan and O'Sullivan[44] suggest that there may be some common themes in the psychological reaction patterns of detainees over time. Each successive stage identified is associated with increasing levels of distress and psychological disability. These observations will be quoted in full as they do not bear editing.

Non-Symptomatic Stage

During the early months of detention, before the primary refugee determination decision, the detainee is shocked and dismayed at being detained, but these feelings are mitigated by an unwavering hope that confinement will be short-lived and that their claim will be upheld'.

Primary Depressive Stage

This follows the receipt of a negative decision by DIMIA and the realisation by detainees that they face a serious threat of forcible repatriation or detention for an indeterminate period or both. The clinical presentation is consistent with a major depressive disorder, with the severity closely related to pre-existing post traumatic stress reactions from past abuses, eg torture, incarceration in political prisons and other forms of persecution). The sense of injustice overwhelms many detainees, who enter a 'primary revolt stage' of non-compliance and non-conformity. The nature of the revolt varies: some become protesters(engaging in hunger strikes and other non-violent demonstrations); others become advocates(attempting to raise public awareness about the realities of detention); and some become aggressors(engaging in confrontations, riots, detainee-guard conflict and interdetainee violence)'.

Secondary Depressive Stage

This typically follows the rejection of the asylum seeker's application by the Refugee Review Tribunal, the ultimate administrative level. The timing of this final rejection may vary, but generally occurs between 6 and 18 months after first being detained. This stage is associated with a more severe and debilitating depressive reaction, with a greater level of psychomotor retardation and/ or agitation. There is a marked narrowing of focus to issues of self-preservation and survival and an overshelming feeling of impending doom. Whereas before most asylum seekers confided in

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[42] Bleich, Avi; Koslowsky, M et al 1997. PTSD & depression: an analysis of comorbidity. *British Journal of Psychiatry* 1997 Vol.170:479–482

[43] Keane, Terence et al.1997. Differentiating PTSD from major depression(MDD) and generalised anxiety disorder(GAD) *Journal of Anxiety Disorder*, 1997 May-June; Vol. 11(3):317–328

[44] Sultan, A.& O'Sullivan Psychological Disturbances in Asylum-Seekers held in long-term detention: a participant observer account. *Medical Journal of Australia* 2001;175:593-596

others about their personal lives and their concerns for family left behind, communication about these issues ceases almost entirely. Some asylum seekers will also enter into a seconday revolt stage that is less aggressive and largely associated with passive, non-compliant resistance and attempts to escape. Many asylum seekers will remain in this secondary depressive stage for the duration of their detention, but a significant number appear to progress to an even more serious state of debilitiation'.

Tertiary Depressive Stage

At this stage the detainee's mental state is dominated by hopelessness, passive acceptance and an overwhelming fear of being targeted or punished by managing authorities. Affected detainees become self-obsessed and trapped in their predicament. Ties to other detainees that were once strong become fragmentary and in some cases disintegrate. There is a significant and chronic impairment in concentration, with detainees being unable to perform even simple tasks. The detainees life can become dominated by paranoid tendencies, leaving them in a chronic state of fear and apprehension and a feeling that no one, including other detainees, can be trusted. Long periods of time are spent alone and some develop frankly psychotic symptoms, such as delusions, ideas of reference and auditory hallucinations. Chronic rage and resentment are directed at the detaining government and the host government. The most disturbed engage in self-stimulatory, stereotypic behaviours, such as repetitive rocking or aimless wandering. Postures and facial expression are consistently downcast and affected detainees may appear to be disengaged or dissociated from their physical environment. Some engage in repeated acts of self-harm or self-mutilation leading to acute hospital admissions'.

What Are the Obvious Symptoms Of PTSD and Depression and How and Where Do They Show?

- Firstly until a refugee is settled and feels safe in his/her new country and have dealt with practical issues of income, housing and school, the condition cannot be treated in its own right. The reason is that added stressors can trigger off the underlying symptoms at any time and complete assessment of PTSD is very time-consuming (Burges Watson 1993)[45]. There needs to be stability in the life of the person, family or community for sustained treatment to be carried out.
- Secondly PTSD symptoms can be put down to lots of other things such as unemployment or relationship stress. This is because the reaction to ordinary stressors which one would under normal circumstances be expected to handle, become grossly exaggerated when the Disorder is the underlying condition. PTSD can manifest as varying degrees of depression in the detention environment. Sultan and O'Sullivan 2001[46] clearly described(above), the deterioration of detainees mental health over time as they wait the outcome of their refugee application sometimes taking years.

[45] Dr Burges Watson, 1993. Assessment & treatment of PTSD. *LMO News* 1993

[46] Sultan, A & O'Sullivan. 'Psychological disturbances in asylum seekers held in long-term detention: a participant observer account', *Medical Journal of Australia,* 2001; 175: 593–596

- Thirdly asylum seekers and refugees who arrived on-shore have gone through great danger to reach Australia—through torture, killings, destruction of villages, removal and disappearance of loved ones. On their way here they, their friends or family members may have died or been threatened. So many will bring with them symptoms of PTSD but because of the stress of arrival the condition may not be immediately noticeable to the asylum seeker or to ordinary observers. **It is frequently misinterpreted as negative behaviour.**
- Fourthly immediate detention in centres may mask the symptoms, covered over by the the day to day survival struggle where at worst they suffer cruel and inhumane treatment and at best inadequate medical attention and a lack of respect. It may be translated into self-harming or suicidal behaviour, acting out of anger& resentment or total despair all associated with severe depression(Sultan & O'Sullivan 2001)[47].
- Fifthly if no end-point to this degrading treatment, they just have to wait. The effect cumulatively can not be imagined. For those that get out there will be obvious unresolved health problems like serious depression. For those who remain the health and mental health problems they do have will doubtless become entrenched, intractable and difficult to treat in the future if there is one.'

[47]Sultan, A & O'Sullivan. 'Psychological disturbances in asylum seekers held in long-term detention: a participant observer account', *Medical Journal of Australia,* 2001; 175: 593–596

LIVING CONDITIONS OF DETAINEES

The detention centre environment is an essential influence on the health and wellbeing of detainees. An extract from Sultan and O'Sullian[48] report is given to obtain a glimpse of the effect of the depriving, punitive and sometimes violent atmosphere on detainees(Appendix 2).

[48] Sultan, A & O'Sullivan. 'Psychological disturbances in asylum seekers held in long-term detention: a participant observer account', *Medical Journal of Australia,* 2001; 175: 593–596

SOME OF THE MAIN EVIDENCE FOR INADEQUATE MEDICAL TREATMENT OF DETAINEES IN DETENTION CENTRES

STUDIES UNDERTAKEN BY PSYCHIATRISTS, MEDICAL PRACTITIONERS AND PSYCHOLOGISTS IN AUSTRALIA AND OVERSEAS

Zachary Steele[49] summarised the enormous body of evidence re psychiatric harm and long term detention. It includes some of the studies below.

Survey of 10 Families

Steele et al 2003[50] undertook a telephone survey of 10 families in one remote detention facility using structured diagnostic assessements. **They found the rates of mental illness documented amongst the 10 families surveyed appear to be unparalleled in contemporary medical literature**.

Detailed Face to Face Assessment of 10 Families

Mares and Jureidini[51] undertook a comprehensive assessment of 10 families referred to the Child and Adolescent Mental Health Service in SA (CAMHS) from a remote IDC. Their findings should give everyone a wake-up call. Assessment took an average of 20 hours per family and followed the ACM[52] services clinical guidelines for the assessment of children and families. Meetings were held with management and plans developed. Follow-up was usually fortnightly or monthly. Many visits were cancelled by ACM. Recommendations were not implemented. New crisis arose and children and their parents deteriorated as time passed. All children were also assessed often multiple times by the state child protection agency, on the grounds that they were at risk of or subject to significant abuse or neglect. These findings were confirmed in subsequent contacts.

Results

All children had at least one parent affected by psychiatric illness. In 5 of the 7 two parent families, both parents had psychiatric illness. In both sole parent families the mother had required several hospitalisations for psychiatric treatment. 14 of the 16 adults fulfilled criteria for major depression. Nine out of 16 met criteria for PTSD and 4 had psychotic illness requiring hospitalisation. Five had made significant, often multiple attempts at deliberate self-harm. These psychiatrists were not given information about medical treatment being given following diagnosis. The lack of comprehensive information about prescribing of psycho-tropics and compliance by detainees with such prescription has clear implications for treatment. **This resulted in recommendations that adequate treatment was not possible while they remained in the IDC environment**. Follow-up about a year later in September 2003 revealed that the wellbeing of 6 of the families had deteriorated with family members becoming increasingly agitated and suicidal as time in detention passed. **This occurred whether they remained in the IDC or moved to the housing complex for mothers and children**.

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[49] Zachary Steel 2003 *Psychitric Harm and Long-term Detention – Summary of Evidence.* School of Psychiatry, University of NSW.

[50] Steel, Z. et al.2003. Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia in Steel, Z. *The politics of exclusion and denial:the mental health costs of Austrlralia's refugee policy*. Keynote address 38th Congress RANZCP Hobart, 12-15 May, 2003.

[51] Mares, S. & Jureidini, J. 2003. Children and Families Referred from a Remote Immigration Detention Centre. Paper presented at *'Forgotten Rights, Responding to the Crisis of Asylum Seeker Health Care, A National Summit*, NSW Parliament House 12/11/03.

[52] Australian Correctional Services – a private company contracted by DIMIA to run IDC's

Conclusion

The authors comment that intervention in child psychiatry aims to address family and broader issues, facilitating normal development and preventing psychopathology. There is focus on early intervention and prevention within the child's family and social context. In immigration detention mental health services available to individuals and families in immigration detention are significantly compromised. The authors believe this occurs not only because of limited access to clinicians, but because recommendations aimed at improving detainees psychological and social circumstances cannot be implemented. In attempts to provide a service, committed staff found themselves reduced to providing assessments and reports that were apparently ignored, despite the extent of psychopathology identified.

Self Harm and Suicide

Michael Dudley(2003)[53] a psychiatrist specialising in suicide intervention and treatment has done an overview of the research concerning self harm and suicide in detention centres. **He describes the Australian government's suicide prevention programs, as the most innovative, progressive and comprehensive in the world**. This contrasts with the endemic self-harm and suicide attempts in IDC's, intimately related to the extremity of the detention environment. Self harm is allegedly punished by being locked in solitary confinement, sometimes for prolonged periods. In his identification of completed suicides he pointed out that the detainees concerned were not all boat people. In the National Survey of Mental Health and Well Being(1997)[54] the community suicide attempt rate among men was 0.3% per annum, while the same figure for women was 0.4%. Calculated annual IDC self-harm rates for men and women are 41 and 26 times the male and female community suicide attempt rates respectively. Methods include hanging, throat-slashing, deep wrist-cutting and drinking shampoo**. Prepubertal children are involved, a trend virtually unknown in the general population**.

Study of 33 Detainees in Villawood

Sultan and O'Sullivan 2001[55] conducted a survey of detainees who had been held in Villawood for over nine months. They had previously been involved in extensive participant observer accounts of detainees. Of the 37 people meeting the criterion, 33 agreed to allow the results to be reported. The survey consisted of a semi-structured interview based on previous observations. Dr Aamer Sultan is a medical practitioner who fled persecution in Iraq after providing casualty medical care to Shiite Muslem rebels. He is a detainee and continued his work on a voluntary basis. He teamed up with clinical psychologist Kevin O'Sullivan who works in Villawood. The detainees originated from 10 countries, with most being from Afghanistan, Iraq, Iran and the former Yugoslavia. The average period of continuous detention was 2 years with the longest period being 3 years and 10 months. Most were men (85%) and half were married (55%) with most of these being separated from their spouses on fleeing to Australia. Despite rejection of their refugee status, over half reported being victims of gross human rights violations before arriving in Australia, enduring abuses such as physical torture(58%) and the murder or disappearance of immediate family members.

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[53] Dudley, Michael J. 2003. Contradictory Australian National Politics on Self-harm and Suicide: the case of asylum seekers in mandatory detention. *Australian Psychiatry*, 2003;11:S102-S108.

[54] In Australian Financial Review 5/4/05 *'Mental health crisis almost a lost cause*, Annabel Stafford. p61.

[55] Sultan, A.& O'Sullivan, K. Psychological Disturbances in asylum seekers held in long-term detention: a participant observer account. *Medical Journal of Australia* 2001; 175:593-596.

Results

All but one of the detained asylum seekers displayed symptoms of psychological distress at some time. At the time of the survey, 85% acknowledged chronic depressive symptoms, with 65% having pronounced suicidal ideation. Close to half the group had reached the more severe tertiary stage. Seven individuals exhibited signs of psychosis, including delusional beliefs of a persecutory nature, ideas of reference and auditory hallucinations. Due to the severity of their symptoms, hospitalisation had been recommended for some of these people by the centre health staff, but authorities had not approved this, except in medical emergencies after incidents involving self-harm. A few have been deported without receiving appropriate care.

Comparison of Asylum Seekers in Detention and Asylum Seekers, Immigrants and Resettled Refugees Living in the Community

Thompson, M. et al.1998[56]

A survey was carried out of 25 detained Tamil asylum seekers held at Maribyrnong Detention Centre, Victoria during 1997 and 1998. The results were compared with those of a parallel community-based study of Tamil asylum seekers, immigrants and resettled refugees living in NSW. The results were that compared with the community group, the detainees were more depressed, suicidal, and suffered more extreme post-traumatic panic and physical symptoms. Levels of past trauma exposure did not account entirely for the symptomatic differences across comparison groups, suggesting, albeit indirectly, that the immediate conditions of detention might be contributing to the mental health problems of detainees.

Summary of the Above Studies

These authors have contributed a description of the cumulative effects of detention on the mental state of asylum. Refugees with greater levels of trauma exposure incrementally increases risk of mental disturbance. Yet there is no policy in place to systematically assess the psychological needs of detainees who have suffered trauma.(Steel & Silove 2001)[57]. In addition the detention environment is a retraumatising influence especially when detention is indeterminate and where the environment is punitive.

[56] Thompson,M; McGorry. P. Maribyrnong Detention Centre Tamil Survey. In: Silove D; Steel Z. eds *The mental health and well-being of on-shore asylum seekers in Australia*. Sydney: Univ.of NSW, Psychiatry Research & Teaching Unit. 1998: 596-599.

[57] Steel, Z. & Silove, D. 2001. The Mental Health of detaining asylum seekers. *Medical Journal of Australia* 2001; 175:596-599

EXTRACTS FROM INSTITUTIONS, COMMITTEES AND INQUIRIES

DIMIA does all its own contracting of medical and health personnel and requires anyone who is contracted to them to sign a confidentiality agreement which forbades them to disclose anything about their work and about the nature of their clients medical conditions. DIMIA has appointed the Immigration Detention Advisory Group (IDAG). When IDAG recommended independent research into the mental health of people held in detention centres this was rejected.

The following extracts reflect the work being done by these organizations in an effort to improve accountability in Immigration Detention Centres, and relevant to the provision of health services.

- Commonwealth Ombudsmans Office(the Office)
- Australian National Audit Office(ANAO)
- Parliamentary Committees
- Human Rights and Equal Opportunity Commission (HREOC) *'A Last Resort'?* National Inquiry into Children in Immigration Detention April 2004

NB media and the web provide information which intersect with the above

THE COMMONWEALTH OMBUDSMAN'S OFFICE

Access To Immigration Detention Centres: Under the *Ombudsman Act 1976*(Cth) the Commonwealth Ombudsman investigates the admininistrative actions of Australian Government agencies and Officers. An investigation can be conducted as a result of a complaint or on its own initiative(on own motion investigation) of the Ombudsman.The Office visits detention centres on a regular basis. Observations are made and complaints received. The Office can advise, recommend and monitor but it is entirely up to the Government or DIMIA as to whether or not it accepts or implements suggestions or recommendations. Some of the following points are taken from the 2001 Own Motion Investigation into Immigration Detention Centres.

Activities Between the Office and DIMIA

The Detention standards were developed by DIMA in 1997 incorporating amendments put forward by the Office. The range of activities engaged by the Office with DIMIA are as follows: regular meetings between senior staff of the Ombudsman's office and DIMIA; monthly meetings between specialist staff in Canberra and staff of DIMIA sections relevant to the inquiry; establishment of protocols between DIMIA and the office; work on case records of the Office and DIMIA; provision of quarterly statistical reports to DIMIA on complaints received by the Office, emerging trends etc: In 2003–2004[58] the Ombudsman received 60 complaints about medical and dental services, relating to access to specialist service providers, the management of detainees suffering a severe psychological impact arising from detention, access to medication, private medical care, the provision of interpreters and the state of medical records. The Ombudsman goes on to say that whereas few of these complaints were upheld, **they believe that the provision of adequate**

[58] Commonwealth Ombudsman Annual Report 2003-2004

medical care for detainees is a serious issue to which the Ombudsman's office plans to give continuing attention in discussion with DIMIA. (See description of health services provided at IDC's in 2001.Appendix 3)

Comments

Whereas health, security and character checks occur within 2 – 3 weeks of arrival in the detention facility(DIMIA Fact Sheet No 88. Processing Unlawful Boat Arrivals, June 2000) it was suggested that the initial assessments conducted by nurses were insufficient to identify preexisting problems facing asylum seeking children[59]. From the problems identified in the HREOC report[60] on unaddressed sight and hearing problems and the pressure from high staff turnover and difficulties in recruitment there is unlikely to be reviews of detainees[61] Medical and health services are sorely stretched due to difficulty in recruitment and high staff turnover[62]. This resulted in crisis management for the most part and waiting lists to see nursing staff for the initial assessment. A general assessment of the meeting of performance measures and benchmarks is discussed by ANAO.

AUSTRALIAN NATIONAL AUDIT OFFICE (ANAO)

The report on Detention Centres Part A[63]deals with the audit to assess the effectiveness of DIMIA's management of its detention agreements with Australian Correctional Services(ACM). From February 1998 until early 2004. an Audit on Global Solutions pty ltd. (GSL) has not yet occurred and will constitute Part B of the report. This report by implication may throw some further light on the provision of medical and health services.

Strategy and Contract Management Plan Lacking

The ANAO found that DIMIA had not developed and documented a strategy for its detention function, nor put in place a contract management plan[64].While there were informal arrangement in place the ANAO found that DIMIA's internal arrangements to coordinate detention services through its contract with ACM were unclear.

Lack of Clarity About Roles and Responsibilities of Key Personnel

There was a lack of clarity around the roles and responsibilities of key personnel and very low levels of contract management training for DIMIA officers. Although DIMIA used a range of mechanisms such as teleconferences and Migration Series Instructions(MSI's) to communicate internal roles and responsibilities, a manual for DIMIA centre managers was not issued until December 2001 and has not been kept up to date[65].

Description of Services to Be Provided

There was limited research into the management of detention services. 'The ANAO was advised that DIMIA's detention agreements described only in general terms the services to be provided by ACM. (It was DIMIA's view that detailed quality standards were incorporated in the Immigration

[59] HREOC Inquiry Report p 483

[60] HREOC Inquiry Report p 497

[61] HREOC Inquiry Report p 493 & 494

[62] HREOC Inquiry Report p 511

[63] ANAO Audit Report No 54 2003-2004 Management of the Detention Centre Contracts Part A

[64] ANAO Audit Report No 54 p4 & 5 summary

[65] ANAO Report summary p5

Detention Standards(IDS)[66]. These were found to be not clear statements of detention service requirements for either outputs or inputs[67].

Meeting Between DIMIA and ACM Informal

The two groups involved in the contract management agreement lacked an agreed formal basis beyond discussions at meetings.[68]

Analysis of Complaints

It was noted that DIMIA did not analyse complaints to identify systemic issues that require attention.[69] (If the IDC's were directly under Commonwealth control such analysis would be a requirement of management).

Risk Management

DIMIA did not identify and document the risks associated with the private provision of detention services. There was no provision to allocate responsibility between DIMIA and ACM to control new risks that arose during the contract, before they materialised, essentially a reactive approach[70].

Subcontracting

The issue of subcontracting is addressed in the Senates Estimates Committee below.

Comment on ANAO Report

Detainees In Isolated Circumstances More Vulnerable There would be many organisations who under the spotlight could be criticised by ANAO this way. But the identified problems refer to detention centres holding extremely vulnerable people many of whom are incarcerated in the desert. In this situation they are rendered helpless and powerless as they await their fate sometimes for years. It is exacerbated by being away from visitors and the scrutiny of citizens groups. In the Play 'Through the Wire'[71] access to visitors helped detainees to remain sane well understood by visitors to Detention Centres from refugee groups. Therefore these deficits assume a greater seriousness and would undoubtedly affect the capacity to provide an orderly and accessible health service.

Protocols Cannot Substitute for Negative Attitudes

All the protocols in the world will make little difference when unauthorised arrivals are seen as illegals and potential terrorists. This attitude comes down from the Executive Government to the officers responsible for the detainees. Attitudes would generally be negative made worse by the use of numbers for addressing individuals and a fear and fortress mentality which would be shared by many employees. In the training no attention is given to Australia's obligations under International Human Rights covenants. UNHCR recommended that DIMIA policy, procedures and training should incorporate detail on international treaty obligations, as well as the 1951 Convention (Inquiry into Ministerial Discretion in Migration Matters UNHCR submission 2002)[72].

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[66] ANAO Report summary p5

[67] ANAO Report summary p5

[68] ANAO Report summary p6

[69] ANAO Report summary p7

[70] ANAO Report summary p10

[71] Through the Wire, written & directed by Ros Horin, Arts on Tour NSW, Canberra Theatre April '05

[72] Submission by United Nations High Commission for Refugees to Senate Select Committee on Ministerial Discretion in Migration Matters 2002.

The Human Rights Subcommittee of the Joint Standing Committee of Foreign Affairs, Defence and Trade[73]

This subcommittee addressed mainly the Detention Centre setting and the abuses of human rights which were occurring such as was addressed under living conditions for detainees(appendix 2). But in recommendations tabled 18/6/01

Number 20 the committee recommends that a review be carried out by DIMIA and ACM into the adequacy of psychological services provided to detainees. It is assumed that this recommendation arose from their observations of and discussions with detainees. In the transcript the frustration of detainees was mentioned frequently.

The Senates Estimates Committee Of Immigration And Multicultural And Indigenous Affairs Committee[74]

This committee provided an interesting insight into what can be viewed as a split in the Department's thinking about health service provision. Note the response given by Mr. Farmer for DIMIA to a question about the use of alternative detention(isolation) for Cornelia Rau.(15/2/05).

> 'They are really quite different things [treatment and placement). One involves an assessment by medical professionals and leads down a certain path. The other is our ongoing responsibility to look at the care and other needs of detainees. Our responsibility is exercised in many cases where there is no psychiatric or other assessment or question in train'.(transcript)

This highlights the inherent conflict between treatment and incarceration; security and care. One is tempted to ask — what constitutes a question about the need for a psychiatric assessment? The department does not appear to use consultation and mutual planning with health professionals so that an appropriate decision can take account of the medical, behavioural and placement needs of a detainee. The medical staff appear to operate as if they had to deal with every difficulty themselves. This may reflect instructions from GSL or maybe being tied up with crisis management the act of referring out just doesn't get done, involving as it does a carefully documented report. It was suggested in the HREOC Inquiry Report that cost was a consideration when considering outside assistance.[75] At any rate there seems to be a reluctance by ACM and later GSL to refer to state health facilities unless in circumstances of emergency.

Mr Davis DIMIA states:

> 'we do access state mental health facilities and specialists in every state where there is a detention facility also other specialists eg obstetricians.
>
> ... Psychologist services at Baxter are employees to one of the subcontractors to GSL . Our contract (DIMIA's) is with GSL and they have subcontracted elements of their service delivery to us to subcontractors'

[73] Joint Standing Committee on Foreign Affairs, Defence and Trade, Human Rights Subcommittee. Hearings 8/2/01. Recommendations tabled 18/6/01.

[74] Senate Estimates Committee for Immigration and Multicultural and Indigenous Affairs. 15/2/05.

[75] HREOC Inquiry Report p 498

He goes on to explain (in context of Ms Rau) that a number of psychiatrists have been involved in the case. The visiting psychiatrist, the specialist who attended Baxter and assessed Ms Rau on 6/11/04 is contracted to the health services subcontractor[76].

Accountability Questions

Out of this array of consultants and sub-contractors, one has to ask about the accountability mechanisms and the means whereby consultation and decision making can happen. An example of the confusion which may result related to a question put to Mr Davis about who would be responsible for medication in the absence of a psychiatric nurse. His answer was a psychologist (when the latter cannot administer medication). This is of concern especially as the Secretary of DIMIA has the power delegated under the Migration Act to take decisions about medical treatment for detainees. The Secretary may or may not accept the advice of a doctor on a case by case basis. Furthermore Mr Farmer made it clear that he exercised this discretion. It is not clear under what range of circumstances the Secretary is asked to make medical decisions but it may be a factor in unnecessary delays in medical treatment.

Case Example: Iranian Detainee With Severe Mental Health Problems

Senator Nettle cites the case of an Iranian detainee who through his lawyer asked for an independent psychiatric assessment.[77] This was refused. In the space of 2 weeks and 8 court appearances. Following an informal request from a judge, this man was transferred to Glenside hospital where he remains. This could well be the case of Behrooz cited by Senator Lawrence in her speech to parliament 22/3/05, a case well known amongst SA refugee activists

> 'He was taken into protective custody by the Public Advocate of SA because this man's mental condition had deteriorated to such an extent that he could no longer remain in immigration detention. He is still gravely ill' (and is still a patient in Glenside hospital)[78]

Comment

The Department's responses to questions demonstrate the dysjunction between the protocols, what is said and what actually happens.

THE HREOC INQUIRY ON CHILDREN IN DETENTION JUNE 2004[79]

This inquiry has covered the field of health and mental health in extensive detail in relation to children and their parents and unaccompanied children. It is the main document examined in any discussion on this matter. Also in this paper material has been drawn from the substantial submission to that Inquiry by the Professional Alliance for the Health of Asylum seekers and their children[80] Attached is the membership of the Alliance which includes all the main players in the fields of medicine, nursing, psychology, refugee health and trauma networks(appendix 4).

[76] Senate Estimates Committee (above) transcript 15/2/05

[77] Senate Estimates Committee transcript 15/2/05

[78] Speech by Dr Carmen Lawrence MP to Parliament 22/3/05,'*Indefinite detention, Cornelia Rau and the denial of mental illness*'.

[79] Human Rights and Equal Opportunity Commission. '*A Last Resort?*'National Inquiry into Children in Immigration Detention. April 2004.

[80] Submission to HREOC Inquiry, by the Professional Alliance for the Health of Asylum Seekers and their Children, May 2002.

Unfortunately most of the content is **currently relevant** even though the numbers in detention are less.

Health Assessment

There were health assessment procedures but they sometimes failed to identify illnesses that were identified shortly after release from detention. The evidence to this inquiry suggested a lack of comprehensive initial health assessments addressing the special vulnerabilities of children seeking asylum[81]. Yet there exists clinical guidelines for the assessment of children as these were used by Mares and Jureidini's in their study of 10 families[82].

Lack of Expertise in Refugee Health

There were no requirements that health care staff have the necessary expertise to treat in areas of refugee health(which includes of course adults as well)[83]. The medical assessment forms did not contain a section which deals with a child's mental health[84]. The shortage of interpreters exacerbates these problems[85].

Staff Shortages and Difficulty Recruiting

The Inquiry acknowledged that despite the efforts of onsite doctors and nurses, staffing shortages and high demand for health services places health staff under great pressure to meet the needs of parents and children[86]. There was also a constant turnover of existing staff[87]. The remote centres had difficulties recruiting and retaining staff, which further exacerbated these pressures[88].

Physical Health Problem

A Doctor working at Woomera confirmed that asylum seekers suffered from ailments that were not common in Australia and for which the medical staff were not fully prepared.

> 'There was severe diabetes, sugar levels high, high – never seen before. There were heart diseases, murmurs. Many things we have never seen because we are such a developed country and these things are picked up when a child is born or blood pressure is monitored. There were the chronic illnesses, asthma-severe asthma. Chronic illness. Then there were the infectious diseases The Hepatitis B's and C's. The infections on the skin, scabies. You could see tracks of scabies under the skin, we had never seen before. It was a learning experience for all of us. I had to ring tropical medicines to find out the treatment and so on. And those were the tropical diseases. Intestinal parasites, we call them liver flukes and so on. Causing severe abdominal pain and so on[89].

The discussion on physical health is also affected by enviromental and mental health problems which underpin many physical problems

[81] HREOC Inquiry Report p 511

[82] Mares,S & Jureidini J.2003. Children & families referred from a remote IDC. Paper presented at *'Forgotten Rights, responding to the Crisis of Asylum Seeker Health Care'* A National Summit, NSW Parliament House,12/11/03.

[83] HREOC Inquiry Report p 511

[84] HREOC Inquiry Report p 472

[85] HREOC Inquiry Report p 504

[86] HREOC Inquiry Report p 494

[87] HREOC Inquiry Report p 493

[88] HREOC Inquiry Report p 494

[89] HREOC Inquiry Report p 489. Dr Bernice Pfitzner, Transcript of Evidence, Sydney, 16/7/2002, p12

At certain time in some centres there were:

- extreme climate and physical surroundings
- insufficient cooling and heating
- inadequate footwear for the terrain
- overcrowding, unsanitary toilets and unclean accommodation blocks
- failure to individually assess pre-existing nutritional deficiencies and conduct comprehensive initial assessments focussed on health and vulnerability of child asylum seekers
- food of variable quality, great monotony and not tailored to needs of young children
- uneven provision of baby formula and special food for infants
- Inadequate numbers of health care staff with paediatric and refugee health expertise and onsite interpreters for purpose of medical examinations
- delays in accessing appropriate secondary health care services
- inadequate preventative and remedial dental care for children detained for long periods
- There were examples of eyesight and hearing problems not being identified in detention but picked up later on discharge[90].

A simple illustration of the mental health impact on health comes from Dr Howard Gorton former psychiatrist in Baxter who said on the *Four Corners* Program:

> The people I saw and treated were the most damaged people I've seen in my whole psychiatric career. Up until that time, I'd never met an adult onset bedwetter. I'd never met someone with psychological blindness. And there were also a few phsysically crippled people who believed they were unable to walk, and this was probably psychological too. (ABC Four Corners 5/4/05)

The Bollen Report[91] identifies the systemic problem in relation to the provision of health services in detention centres. The issue which they were asked to consider was whether there was a clear understanding amongst Department and ACM staff regarding the level of health care to be provided in the centres.

> 'The review identified differences in priorities amongst both ACM and DIMIA staff. Operational staff seemed to view health services as a necessary fulfilment of a contract rather than addressing basic need. ACM management in most of the centres appeared to place most emphasis on security; DIMIA placed most emphasis on processing. Health care should be more than the provision of health services and must take into account issues of primary prevention including appropriate diet and extent of activity necessary to maintain health including mental health, and prevent illness including symptoms resulting from cultural as well as language misunderstanding'[92]

Delays in Getting Treatment

The Inquiry cites a report of Department of Human Services, SA[93] in August 2002 on delays in the process of referring children to state mental health services. The report concluded:

[90] HREOC Inquiry Report pp 496-500

[91] Dr Michael Bollen & Dr Chris Bollen. Review of Health Services at Immigration Detention Centres and Immigration Reception and Processing Centres. October-November 2001.

[92] Bollen Report in HREOC Inquiry Report p 465.

[93] DHS Social Work Assessment Report on the circumstances of Children in the Woomera Immigration and Processing Centre.21/8/02 pp 11-12

'The process of approving and enacting referrals to external mental health services is cumbersome and slow. These delays (of many weeks) place many children at an unacceptable level of risk in the interim. There are practical difficulties with follow-up to do with access to the families, transport difficulties and changes of staff sometimes withdrawing a previous referral[94].

Comment

The final delays in getting Ms Rau to the Glenside Psychiatric Hospital in SA were due to the resistance of the GP in Baxter to schedule her. He only did so when the case went public(ABC Four Corners 5/4/05).

Release From Detention on Mental Health Grounds Was a Rarity

Recommendations to release from detention on mental health grounds , has depended entirely on whether a child is unaccompanied, or detained with parents or other family members. Since January 2002 just under 20 unaccompanied children have been placed in the community in home-based places of alternative detention on the basis of mental health recommendations of state authorities[95]. Recommendations to release or transfer children accompanied by their parents on mental health grounds were almost never acted on (due to strict conditions under the Migration Act and regulations)[96].

Standards In Detention Centres

The HREOC inquiry stated,

'it is unclear to the Inquiry why the Commonwealth has not approached the operation of detention centres in a more comprehensive manner. In particular, it is unsatisfactory that after more than a decade of administering a mandatory detention policy, the primary guidance from the Parliament regarding detention is the text of sections 189 and 196 of the Migration Act which simply require the detention and release of persons in specified circumstances. There is no Commonwealth legislation setting out the minimum standards of treatment of children while still in detention, and no legislative guidance as to what the content of any standard should be[97].

Human Rights Commissioner Dr.Sev Ozdowski when comparing prisons with detention centres said,

'Australia's detention centres are run by a private company, Global Solutions Ltd, who were given the contract by the Department of Immigration. This arrangement means that what goes on inside is not open to public scrutiny. It doesn't give any rights, or rights to review or complain—it doesn't give any transparency because it is not a public Act of Parliament- - and you cannot challenge conditions'. If the Federal Government insists on keeping the detention regime, the Human Rights Commissioner says it must legislate how the centres are run, conditions within and the length of time detainees are required to stay. 'You don't give administrative authorities the right to lock up people for indetermined periods of time'[98].

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[94] Above DHS Report cited in HREOC Inquiry Report p11–12

[95] HREOC Inquiry Report p 425

[96] HREOC Inquiry Report p 425

[97] HREOC Inquiry Report p 878

[98] *Canberra Times* 26/3/05 'From Refugee to Human Rights Commissioner' by Emma Tinkler.

MEDICAL AND HEALTH BODIES CONCERNED ABOUT THEIR WORK IN DETENTION CENTRES

PROFESSIONAL ALLIANCE FOR THE HEALTH OF ASYLUM SEEKERS AND THEIR CHILDREN

At the November 2003 conference of the Alliance (membership see appendix 4) the key findings were as follows:

- Rates of psychopathology in detainees in Australian detainees, including children are unparalleled in contemporary medical literature.
- Children in detention show extremely high rates of depression, PTSD, anxiety and developmental problems.
- Rates of suicidal and selfharming behaviour are between 42 and 26 times higher for men and women respectively than the community annual suicide rate.
- Severity of psychiatirc symptomatology increases with length of time in Immigration Detention
- Experiences in detention exacerbate pre-existing trauma.

See also Appendix 1 for extracts from the position statements of the AMA, ANF, RANZCP; RACGP, RACP, and APS who contributed to these findings.

Case Examples Drawn From Alliance Submission

Here are a selection of case examples from health workers with concerns about services to patients.

Re Medical Facilities Case Study E

Provided by Dr Paul Carroll,GP Registrar Perth & Dr Annie Sparrow, Senior Registrar in Paediatrics, Perth[99] These comments are made about Woomera but these problems affect Baxter and Villawood and may apply to others as well.

> There needs to be agreed and appropriate clinical guidelines for the management of medical problems beyond the scope of the clinic to treat. This includes the decision to transfer patients to Woomera Hospital as well as arrangements with named consultants/teams in major specialities in Port Augusta or Adelaide'.

[99] Alliance submission p 22.

In particular they wrote of the limited current arrangements for the care of patients requiring acute and chronic psychiatric management on both an in-patient and out-patient basis. They noted the inadequate supply of appropriate interpreters of both genders to meet the cultural need of most of the women in detention who could not discuss health matters through a man. They write of inadequacies in staffing levels and in particular the need for a senior medical practitioner within ACM to provide advice and support for doctors who are often temporary/agency doctors. They mention the need for direct leadership to encourage and ensure that clinic staff treat detainees with respect and compassion.

Re A Woman Who Gave Birth. Case Study F[100]

Dr. Louise Newman, psychiatrist.

This woman described increasing feelings of depression and despair over the past two months. She admitted to suicidal ideation and thoughts of strangling herself. She felt that if not under surveillance she would harm herself. She said she had little reason to live. The onset of this depression appears to have been in the post-partum period. The patient described her distressing experience of giving birth to her first child alone and without an interpreter. She described her anxieties about caring for an infant in detention and fears for her daughter's future.

This woman was severly dehydrated, was not eating, had mastitus and a urinary tract infection, was in a wheel chair because she could not walk. She and her husband had been in detention 10 months.

Re A Family With A Toddler And A Baby In Detention For 10 Months Awaiting Decision On Refugee Status. Case Study Z[101]

Dr Sarah Mares, Child & Family Psychiatrist through an interpreter.

The parents begged the psychiatrist to take the children and find a place away from the detention centre until they can care for them again. They fear their son will change to a savage not a human being. He doesn't trust them anymore. He can't play, he won't eat, he can't sleep well. The mother had given birth to the second child in a hospital hundreds of kilometres away by caesarean section[102] which she did not consent to. No interpreter was provided to explain the reason for it. She did not see her baby for some days and was told she could not breast feed him in case the antibiotics got into the milk. Her wound is still weeping and remains painful. Her son's behaviour deteriorated while she was away and it has not improved. She is depressed. Her husband is frustrated and angry and they feel totally helpless.

Re Children In Detention. Case Study A[103]

Drs Sparrow and Carroll

'There are a number of children who have been born in detention and who often appear to be developmentally delayed. They have no grass, no dedicated area, no space to be with other infants, play and interact, and hence no stimulation. Many of them show signs of significant post-traumatic stress disorder and are clingy, withdrawn, quiet and difficult to engage. Secondary nocturnal enuresis is a common problem in child detainees, for which the only current solution is

[100] Alliance Submission p 23

[101] Alliance Submission p 27

[102] The following reference has been added by the writer of this report because such circumstances might give rise to a post traumatic condition.(Menage, Janet 1993 PTSD in women who have undergone obstetric and/or gynaecological procedures: *Journal of Reproduction and Infant Psychology* 1993; Oct-Nov Vol 11(4) 221-228)

[103] Alliance Submission p 18

the provision of nappies. Children are commonly known to be sleeping with their parents again out of fear and anxiety. There are no counsellors available for children and the lack of recreational facilities and absence of routine compounds their problems'.

16 Year Old Unaccompanied Afghani Boy. Case Study B[104]

Mr Roshanak Vahdani, mental health nurse

'He cried continuously, expressing hopelessness about living and repeatedly telling me that he wanted to kill himself. He reported being depressed and agitated for weeks. He had classic symptoms of a major depression—depressed mood, suicidal ideation, sleep and appetite disturbances and severe agitation. He had not seen any health professionals since arrival 6 months ago and did not want me to tell the authorities because he felt he would be punished and put on 'suicide alert' (which can mean a padded cell under observation) His father was taken by the Taliban as a political prisoner and noone knows what has happened to him, his brother has gone missing so his mother sent him to Australia to protect him from further persecution. He has a stutter which impedes communication when under stress'.

10 Year Old Boy With Diabetes. Case Study C[105]

GP who gave his name to HREOC working in a detention centre

This boy's diabetes had always been managed by his mother up until their time in detention, and had been well controlled. She was not allowed to care for the boy's illness in detention. When the boy was hospitalised in city x his mother was allowed to manage the diabetes and his condition stabalised. This cycle occurred a number of times. This case study demonstrates the disempowering effects of detention on the ability of parents to care for their children.

Case Example drawn from the Villawood Detention Centre

Sultan and O'Sullivan[106] made the following comments about Villawood:

'At times we have observed harsh and uncompassionate handling of asylum seekers by staff. Detainees are routinely handcuffed during transportation to and from the facility for medical or legal appointments. Access to medical services sometimes has to be negotiated through correctional centre staff, especially after hours or after security incidents. This means inevitable delays which occur on a regular basis and heighten frustration. Concerns have been raised about doctors authorising sedative medication for containment and removal of detainees rather than for genuine medical reasons. Multiple complaints have been lodged by detainees with the Commonwealth Ombudsman, HREOC and the NSW Health Care Complaints Commission about inadequacies in medical and dental care. Apart from official hearings and interviews, interpreter services are not generally available, leaving detainees with poor English isolated and unable to communicate'.

The lack of trust engendered by these experiences underminds medical assistance of any kind.

[104] Alliance Submission p 19

[105] Alliance Submission p 20

[106] Sultan, A & O'Sullivan, K Psychological Disturbances in Asylum Seekers held in long-term detention: a participant observer observer account. *Medical Journal of Australia* 2001; 175:593-596

Comment on Case Examples

The services for such traumatised people are just not available and as suggested by the HREOC inquiry report and studies already described, mental health assistance tends to be less effective the longer people are in detention without an endpoint to their incarceration. Nor can mental health be divided from overall health and well-being as the above examples illustrate.

MEDICAL REFERRAL PROCEDURES FOR DETAINEES DISCHARGED TO THE COMMUNITY—HANDOVER ISSUES

Dr Christine Phillips[107] works with refugees who arrive in the ACT mostly from remote detention centres or more recently Nauru. So her comments do not directly relate to Villawood or Maribyrnong. Her criticisms regarding medical referrals relate to onshore remote IDC's especially Baxter.

> 'Baxter provides no handover notes, or sometimes a handover note that would not meet the most basic medical standards ie medications not specified. I cannot recall a case when a refugee on ongoing medication has been provided with sufficient medication to tide them over the few weeks until they can see a community doctor. These can be very frustrating consultations as neither the doctor nor the patient is aware of the name of the medication which needs to be taken'.

She contrasts this with Port Hedland IDC where often(not always) refugees were provided with copies of their records. She cites the good model provided by the medical handover of refugees from Nauru IDC where health services is managed by the International Office for Migration (IOM). **All patients were provided with their own files, and understood what was in them. This meant that continuing their care was very easy**.

Dr Phillips writes of her concern about this discontinuity of medical treatment for women and children from onshore detention centres on bridging visas released into the community. These children are much better off in the community, but still remain in a precarious state as they are not provided with access to medicare

> 'I am aware of one woman released into the community with a serious and ongoing condition, who cannot access publicly funded services. Despite the fact that her ongoing need for these services was well documented in the IDC, there was no effort to ensure that she could access them once discharged'.

Included in the Alliance submission is a statement from Source S, a medical doctor[108]. He explains that detainees with health problems can be released(when deemed a refugee) at short notice without adequate follow up arrangements/documentation etc:- In his experience medical records are rarely provided and obtaining medical information about detainees after their release is highly problematic.

> 'I saw a young woman from Iran in late 2000. She was an insulin dependent diabetic and had been released from Villawood the previous afternoon without insulin or other materials. She was provided with insulin and the local diabetes clinic gave her enough syringes etc until more could be arranged. DIMA(as it was then) needs to be aware it could be liable for any poor outcome related to this issue'.

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[107] Dr Christine Phillips, Senior Lecturer in Community Health at ANU Medical School and general practitioner who works in refugee health.

[108] Alliance Submission pp 43&44

DUTY OF CARE

The Ombudsman's report (2001)[109] makes it very clear that ACS and DIMIA have a duty of care to detainees under their control. He discusses this at some length within a legal framework and cites the Parliamentary Joint Committee of Migration and Immigration Detention Centres Inspection Report(1998) as lending support to this opinion. Furthermore notwithstanding DIMA's contractual arrangements with ACS, it is his view that the Department is not able to pass on its duty of care to ACS but rather remains the responsible body. In other words it is a non-delegable right.

Health Professionals and Duty of Care

There are a number of concerns:

- Managers of centres often do not act upon the advice of health professionals about the treatment required by detainees, whether children or adults[110] (Mares&Jureidini 2003)[111], Senator Nettle's testimony in Senate estimates hearing 2004[112]. Case examples provided by Wayne Lynch in the Alliance submission illustrate this graphically (below).
- Due to contractual arrangements that are required to be signed at the time of employment, professionals are not allowed to voice their concerns, especially those professionals who have been employed directly from overseas.
- Due to fear of being sacked some professionals would feel they were deserting their needy patients should this occur.
- In desert IDC's especially the isolation affects sympathetic staff and they lose perspective and may well feel that noone outside cares what happens to them or their patients. Secondary traumatisation to staff is a feature of working closely with patients who have suffered terrrible experiences.(Blair & Ramones1996[113],Straker & Moosa1994[114])

The Alliance submission states that all professionals have a duty and an obligation to become aware of human rights violations and call attention to them, and that, those who take this step need to be actively supported by their respective professionals bodies and by the rest of the community. The professional bodies need to provide effective machinery for the investigation of unethical practices by medical and health professionals in the field of human rights[115]. See extracts from position statements of AMA, RACGP, ANF, APS (Appendix 1).

Comment

Medical and nursing staff are hard to come by in isolated detention centres. It is understood anecdotally that many of the medical staff are born overseas, some being on visas themselves and that many nurses are recruited from New Zealand. If true, either way these professionals would have little appreciation of the complexities of the different state health systems and have little idea of prevailing values and standards taken for granted in the Australian Community. (Inadequacies of referral from detention centre to community is discussed above). Due to their contractual obligations, they have no access to their professional body for advice and support. It is understood that the AMA does occasionally receive information from whistle blowers in Detention Centres. It cannot be followed up as the professionals concerned do not wish to be

[109] Commonwealth Ombudsman 2001 Own motion investigation into Immigration Detention Centres p 27

[110] HREOC Inquiry Report p 417

[111] Mares, S &Jureidini J 2003 Children and Families referred from a remote Immigration Detention Centre. Paper presented at *'Forgotten Rights, Responding to the Crisis of Asylum Seeker Health Care, A National Summit*. Available from School of Psychiatry, University NSW.

[112] Senate Estimates Committee for Immigration & Multicultural & Indigenous Affairs. Transcript 15/2/05

[113] Blair, D.T.; Ramones,V.A.1996 Understanding vicarious traumatization. Journal Psychosocial Nursing, Mental Health Service(US) 34;(11) p24-30

[114] Straker,G; Mossa, F.1994 Interacting with Trauma Survivors in contexts of continuing trauma. *Journal Trauma Stress*(US) July, 7(3) p 457-465.

[115] Adapted from the World Medical Association Resolution on Human Rights, adopted October 1990 and amended October 1993, Sept.'94 and Sept.'95 in *Submission of Professional Alliance for the Health of Asylum Seekers and their Children*. p34

identified in case they lose their jobs and for some their visas. A few medical personnel and a number of nurses who have previously worked in Detention Centres have spoken about their concerns regarding the environmental and psychological impact of no end point incarceration on detainees. Below are some case examples.

Case Studies Illustrating Unsuccessful Attempts by Practitioners of Exercising Duty of Care in Relation to Clients from Alliance Submission

Wayne Lynch, nurse/counsellor[116]. He worked in Woomera for 4 months as an RN and for 3 months as a counsellor. In latter role he worked approximately 80 hours a week and paid for only 40 hours.

> 'As the only counsellor for staff and up to 1000 detainees I was not provided with a room in which to work nor an interpreter. On a daily basis I was asked to do self-harm risk and mental health assessments. I left Woomera because I was at odds with management over a number of unacceptable practices and inhumane treatment of detainees'.

As counsellor he wrote to DIMA/management no less that 20 times with concerns about particular detainees and never received a written response. He was reprimanded by centre management for writing to DIMA.

The examples he gives make chilling reading and are included in (appendix 5) Even though they apply to Woomera, testimony of this kind has come from other centres(Sultan and O' Sullivan in Villawood[117]). He concluded by describing the frequent challenges he faced from management and guards who argued that

> 'presenting physical and mental ill health in detainees was psychosomatic and contrived to achieve an outcome, and that any referral or relocation outside the centre was inappropriate'[118]

This mindset is identified again and again by the HREOC Inquiry, parliamentary committees, testimony of psychiatrists like Louise Newman and Sarah Mares. It seems to provide the prism through which all behaviour in detention centres is judged by management. The Cornelia Rau case is now a public illustration of how it prevents detainees receiving the treatment they require.

Postscript re Justice Finn's judgement in the Federal Court of 5/5/05 re two Applicants S and M(both Immigration Detention detainees) whose treatment for their psychiatric condition in detention was manifestly inadequate

> 'Suffice it is to say for present purposes that it is claimed that the Commonwealth has breached its duty to ensure that reasonable care is taken of S and M in detention in relation to the treatment of their respective psychiatric conditions. That breach (or breaches) is not attributed to any specific acts of negligence on the part of their treating medical practitioners. Rather it is ascribed to systemic defects in the manner in which mental health services are provided in Baxter, which defects are responsible for the deterioration in the medical conditions of S and M with resultant increase in risk of self-harm or suicide.'

See entire judgment at <www.austlii.edu.au/au/cases/cth/federal_ct/2005/549.html>.

[116] Alliance Submission p 34

[117] Sultan, A & O'Sullivan, K. Psychological Disturbances in asylum seekers held in long-term detention: a participant observer account. MJA 2001; 175: 593-596

[118] Alliance Submission p 36

PHYSICAL & MENTAL HEALTH FOR ASYLUM SEEKERS & REFUGEES IN THE COMMUNITY (OUTSIDE DETENTION CENTRES)

PHYSICAL HEALTH IN THE COMMUNITY FOR ASYLUM SEEKERS & REFUGEES

Studies

In the 12 month period 2000-2001 in Sydney an audit was carried out by the Asylum Seekers Centre of primary care needs of 102 asylum seekers was carried out at over a 12 month period 2000-2001[119]. The patients were mostly from Africa, the Middle East and South America. These patients did not have access to medicare. In 45 cases there was a history of torture or trauma. Their mean age was 33.5 years; range infancy to 68 years and 61% were men. A significant proportion required specialist care and experienced problems accessing hospital –based services, especially inpatient care, as well as difficulty paying for expensive drugs such as triple therapy for helicobacter pylori infection, and antipsychotic drugs. This was the hierarchy.

MEDICAL CONDITION	%
psychological, including depression, anxiety, PTSD	26
musculoskeletal, including previous injuries, trauma	24
circulatory, including hypertension, heart disease	18
digestive, including peptic ulcer	16
infectious deseases, including TB, HIV, Hep B	12
urological, including urinary tract infections and prostatitis	9
neurological including headache, epilepsy	8
endocrine including diabetes	7
pregnancy	6
female genital conditions	6
opthalmological conditions	6
skin conditions	5
dental problems, incl. dental abscess, gum disease	3
anaemia	2

An earlier Sydney study in 1994[120] of 40 asylum seekers attending the Centre suggested that most were suffering from psychological and physical symptoms sufficiently serious to warrant medical assessment. Thirty reported exposure in premigration trauma, 10 had been subjected to torture, 10 reported gastrointestinal disease, 9 musculoskeletal complaints, 6 gynaecological problems and one had hepatitis. Dr Mitchell Smith, Director NSW Refuge Health Service[121] found in his work that health problems are compounded by socioeconomic disadvantage they experience in Australia. This dovetails with United Kingdon studies which found that many of the basic needs

[119] In Harris & Telfer MJA 2001:175: 589-592.

[120] Sinnerbrink, I; Silove D.M;Manicauasagar,U.L. et al. 'Asylum seekers: general health status and problems with access to health care'. *Medical Journal of Australia* 1996; 165;634-637.

[121] Dr Mitchell Smith 2001 Asylum Seekers in Australia *Medical Journal of Australia* 2001;175:587-589.

of asylum seekers overlap with those of deprived or excluded groups, ethnic minorities or new entrants to the country'[122] Harris and Telfer 2001[123] explain that asylum seekers present with the physical sequalae of torture or other violent trauma which may not have received adequate attention in their countries of origin. This includes malunited fractures, osteomyelitis, epilepsy or deafness from head injuries or nonspecific musculoskeletal pain or weakness. They explain that rape victims in addition to the psychological impact of rape, there may be a risk of HIV or other sexually transmitted diseases.

CLUSTERS OF HEALTH PROBLEMS ENCOUNTERED BY GP'S

The RACGP website[124] provides a description of presenting health problems of refugees and asylum seekers, with a very similar profile of illness to the surveys described above. They note that in addition to the range of complaints similar to those of the rest of the Australian population, the following health problems are likely to be common amongst refugees:

- Psychological disorders eg PTSD, anxiety, depression and psychosomatic disorders,
- Direct physical consequences of torture eg musculoskeletal pain or deafness,
- Under recognised and under managed hypertention, diabetes and chronic pain,
- Poor oral health, a result of poor nutrition and diet, lack of fluoridated water, poor dental Hygiene practices and limited dental care in the past,
- Infectious diseases including TB and intestinal parasites,
- Delayed growth or development in children.

Medicare Access

The College points out that a significant minority of refugees and asylum seekers have no access to the benefits of Medicare or the PBS. In 2003, 33% of these people were denied work rights and medicare and therefore have very limited access to either preventative or curative services. This situation adds to psychological distress and exacerbates PTSD symptoms. The College sees access to health care as a basic human right and is committed to the maintenance and extension of Medicare funded access for all asylum seekers and refugees. It is concerned that lack of access to health services could pose a small but potential health risk of communicable diseases such as TB, hepatitus and HIV infection. It thinks that protocols need to be improved regarding the identification and treatment of communicable diseases.

Barriers to Medicare Access

Harris and Telfer[125] describe the situation where those asylum seekers who arrive with a valid visa must apply for asylum within 45 days of their arrival in Australia to be eligible for essential medical services through medicare, the Pharmaceutical Benefits Scheme(PBS) and work rights. In exceptional circumstances asylum seekers in this situation can receive help form the Asylum Seekers Assistance Scheme (ASAS). This is a Commonwealth Government scheme administered by the Red Cross which provides financial assistance and healthcare to a small proportion of eligible

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[122] Bardsley, M & Storkey, M Estimating the number of refugees in London *Journal Public Health Medicine* 2000; 22: 406-412; The health needs of asylum seekers living in the community. *Medical Journal of Australia* 2001; 175: 589-592.

[123] Burnett, A & Peel, M The health of survivors of toture and organised violence *BMJ* 2001; 322: 606-609 in Harris, M. & Telfer, E.

[124] www.racgp.org.au

[125] Harris, M. & Telfer, E. *MJA* 2001; 175; 589–592.

asylum seekers. The implications of not being covered by medicare are serious. For example the NSW Health Department charges patients who are ineligible for Medicare for inpatient and outpatient care. At a metropolitan referral hospital, these charges are $695 per day for inpatient care and $80 for outpatient care. An assurance of payment is required before treatment is provided (cash, credit card or guarantee from an Australian citizen). When such an assurance is not forthcoming , the patient is to be informed that he or she will receive only the minimum and necessary medical care to stabilise their condition.

Implications

With at least 33% of refugees/asylum seekers not covered by medicare and work rights many adults and children are socio-economically disadvantaged. This raises serious ethical implications for doctors and health workers in the front line—general practitioners and hospital registrars. They are faced with the choice of denying basic health care or treating at cost to themselves and their organisation. The RACGP is concerned about the small but potential public health risk of communicable diseases such as TB, hepatitis and HIV infection—a totally unnecessary problem in a country like Australia.

MENTAL HEALTH IN COMMUNITY FOR ASYLUM SEEKERS AND REFUGEES

PTSD has been discussed in relation to its increased impact for those held in detention. In the community PTSD may not manifest immediately until individuals and families have their basic needs met and are feel safe and secure. The second condition cannot be met for those on TPV's or Bridging Visas. PTSD will frequently be overlain by the physical symptoms. So the presentation will be wide-ranging and frequently bizarre in terms of the norm. Just as Dr Howard Gorton former psychiatrist at Baxter said he had never seen in his life practice such damaged people, those in the community may well present alarming, complex and perplexing symptoms which are difficult to treat.

Treatment for PTSD and Other Mental Health Illness In Specifically Mental Health Services

There is a 'terrible shortage' of psychiatrists according to Australian Health Care Reform Alliance president John Dwyer. The number of psychiatrists rose by just 120 to 2097 between 1995 and 2001 or around 10.8 for every 100,000 people(Australian Institute of Health and Welfare).[126] The shortage is more dire in public hospitals, which showed a 10.5 % decrease in clinical staff for admitted patients between 1993 and 2002 according to the 2004 National Mental Health Report.

Psychological and Social Work services are vital in working with PTSD and provide both the individual and family oriented approach required for a total treatment approach. Currently they are not covered by medicare for this purpose and increasingly work in the private sector, inaccessible to refugee groups. Due to their small numbers the psychiatrists tend to be mainly involved in

[126] *Australian Financial Review* 5/4/05 'Mental Health Crisis almost a lost cause' by Annabel Stafford

prescribing medication and ideally should work closely with the other two professions. All require specific training in PTSD from experienced practitioners as well as theoriticians

Treatment for PTSD and Other Mental Health Problems in Community Based Services

Harris and Telfer 2001[127] describe in their paper the work of the Victorian Foundation for Survivors of Torture and the West Melbourne Division of General Practice. These organisations have produced a guide to the care of refugee patients in general practice[128] [129]. They emphasise the importance of engaging a professional interpreter and providing adequate education and information to refugee patients, including the cost of prescriptions, investigations and referrals. The key issues they described for consideration in the assessment include preventative care, chronic conditions which may have been delayed or inadequate, dental care, developmental problems, mental health problems and injuries and infectious diseases.

In general practice the priority of treatment will be physical illness. Mental health services are not available to the extent required in the general population especially those without health cover. The problem is greater for refugees without medicare and they require skilled culturally sensitive interpreters to access health services. Treatment for PTSD is a pipedream for all but those with access to the small number of specialist programs eg STARTTS in Sydney, the Brisbane Refugee and Asylum Seeker Health Network and the Victorian Foundation for Survivors of Torture. Small NGO's have their limitations due to funding and they cannot replicate themselves like government agencies and large basic agencies such as St Vincent de Paul, Smith family and Salvation Army. The latter welfare organisations are an important source of assistance for refugees and asylum seekers. Many lesser known community organisations do as well. Dr Sharon Pickering's[130] undertook a detailed study in NSW. on local welfare and health organisations who shoulder the burden when asylum seekers are ineligible for medicare and other basic services. It illustrates the divestment of responsibility for this group by the federal government and the inevitable transfer of that responsibility onto adhoc funded community organisations and volunteers.

Minimally it is necessary to:

- Extend medicare coverage to TPV's and all Bridging visa holders
- Widen the professional groups covered by medicare
- Extending the training in complex PTSD so that in future those treating health problems will have some understanding of the condition and be able to see ill-health in the context of what has happened to them. Training of medical and health providers is important and should be taken up by the AMA, ANF, RACP, RANZCP and APS. In some organisations this is already occurring.

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[127] Mark F Harris & Barbara L Telfer. The Health needs of asylum seekers living in the community.
Medical Journal of Australia 2001; 175: 589-592

[128] Caring for refugee parents in general practice. Victorian Foundation for Survivors of Torture, on behalf of the Western Melbourne Division of General Practice, 200 in Harris & Telfer. Ref above

[129] Managing survivors of torture and refugee trauma: Guidelines for General Practitioners: NSW Service for Treatment and Rehabilitation of Torture and Trauma Survivors(STARTTS), General Practice Unit, SW Sydney Area Health Service, Centre for Health, Equity, Research and Evaluation. NSW, Sydney in Harris & Telfer 2001 Ref 127

[130] Dr Sharon Pickering 2001 exact reference not available. Study was on restriction of commonwealth funded programs to TPV's and Bridging Visa Holders & demand on community services & volunteers.

CASE EXAMPLES OF ASYLUM SEEKERS AND REFUGEES PROBLEMS IN ACCESSING BASIC HEALTH AND SPECIALIST SERVICES FOR PHYSICAL AND MENTAL HEALTH PROBLEMS

These have been taken from the Alliance submission to the HEREOC Inquiry[131]

Case Example From Medical Doctor Of 27 Year Old Man. Case Study N[132]

Source S, a medical doctor

His case was before the Refugee Tribunal. He had experienced trauma during imprisonment in country of origin. Sleep problems had resulted(classic outcome of PTSD). For 3-4 months he had abdominal pain, diarrhoea and fever. His weight had gone down to 43kg. The provisional diagnosis was TB or malignancy. He was referred to senior gastroenterologist who tried to admit him to hospital for further investigation. The hospital would not authorise his admission as he did not have a medicare card. After multiple entreaties by the doctors involved the Red Cross lodged an application with the department for financial coverage of his health costs in a public hospital. This took 5 days to organise on top of the existing delays. He was eventually admitted to hospital a week after the original recommended urgent admission date. He was treated with antituberculosis chemotherapy and has made a slow recovery over 6 months.

6 Year Old Boy With Hearing Loss Case Study O[133] This Case Was Provided By the Refugee Claimants Support Centre(RCSC), Brisbane and a Migration Agent

This boy son of a family of refugee claimants was referred for a hearing test with an audiologist by school teachers. There were lots of associated physical, learning and behavioural problems. Two hearing aids were fitted by the audiologist. The family was presented with a bill of $400. The family had been living on a bridging visa without work permission and without a medicare card for almost two years. They had been surviving on charity, homeless and hungry at times, without access to the Asylum Seekers Assistance Scheme.

The audiologist decided not to take the child's hearing aids away from him. Instead he changed their procedures and in future children without initial presentation of medicare card will not be seen. **The little boy is encouraged to do without the hearing aid when he is home so that the batteries will last longer**. Both children of this family do not have access to regular health checks, immunisation or treatment of childhood diseases. Medication is not affordable without a medicare card.

6 Year Old Boy With Injured Shoulder Case Study P[134] Provided by RCSC Brisbane & Migration Agent

A six year old boy from an asylum seeker family of five, who had been waiting for a final decision on their application for protection for over four years, was given a small bicycle as a gift from a community group. He and his brother were full of joy over the gift and immediately rode the bike. The boy fell and injured his shoulder. He went to hospital and after overnight stay was released with shoulder and arm set in plaster. The bill for treatment and hospitalisation came to several

[131] Alliance Submission to HREOC Inquiry
[132] Alliance Submission p 40
[133] Alliance Submission p 40
[134] Alliance Submission p 41

hundred dollars. With no work permission and no medicare and living on charity they could not pay. They were threatened by the hospitals debt collector re court proceedings over the debt. **The parents became anxious over what this debt may mean for their case decision by the Minster**, and the little boy said he would try his best never to get sick again.

NB above two cases of problems considered straightforward for Australian citizens are compounded by the family's poverty, uncertaintly about the future and being made to feel dependent. The fear engendered by this chronic situation can hardly be imagined.

Father and Daugher – Case Study Q[135] from RCSC Brisbane & migration Agent At the South Brisbane immigration & Community Legal Service

A 12 year old girl had to bear the burden of translating for her deeply depressed, suicidal and paranoid father. They had been on bridging visas for over 3 years and their application process was traumatic,- not being believed, threatened with being sent back to his country where he believed they would be killed. His condition deteriorated and he locked his family into their accommodation, threatening to kill himself and his family. He used her as a go-between media and police to secure their safety.

Mother and 3 Children Case Study R[136] Provided By A Coordinator In the Refugee Claimants Support Centre (Brisbane) and a Migration Agent at the South Brisbane Immigration and Community Legal Service

They are on their own here. The father never made it to the airport. They are in the community awaiting for a protection visa. The girls do not leave their mothers side. The teenage son with special duties as 'head' of the family cannot provide for them. He has limited English and has as yet no work skills. Shelter and food is provided by charitable organisations and the community. The 14 and 10 year olds have been prevented from going to school for almost a year by government policy before the Refugee Claimants Support Center was able to receive a ministerial exemption for them. Their future is insecure.

NB All this stress and insecurity and we as readers do not know what background this family came from and how any trauma they had experienced was affecting them. Even if the mother and her children obtained a TPV, since August 29th 2004 they are barred from applying for permanent residency and therefore reunion with husband and father if he were indeed still alive.

19 Year Old Woman With Hiv Case Study T[137] Provided By a Medical Doctor

She is a refugee from Ghana. Her parents are dead. Her refugee status is still pending and she has no access to medicare. She presented at 5 months gestation and tested as HIV positive. The patient had no knowledge of this and was very upset. A second test again was positive.

It took several weeks to get her treated with antiviral therapy. This was critical in preventing her child from becoming infected with HIV. **Finding a hospital where she could be delivered was also difficult and took several weeks to arrange**. She was subsequently delivered and fortunately the infant is HIV negative.

[135] Alliance Submission p 42

[136] Alliance Submission p 43

[137] Alliance Submission p 44

FEDERAL – STATE RELATIONS

The formal relationship between State and Federal on Immigration is very limited, ie a standing committee which meets twice a year and a Ministerial council meeting once a year. Then there is the newly established committee in NSW on overseas settlement issues set up by the Premier who is inviting a DIMIA representative through the minister. Are the other states better served? The Palmer and Senate Committee on mental health inquiries may touch on the area of federal/ state relationships with regard to health coordination for inmates in detention. The ANOP's audit report, No 54, 2003-2004 mentions that the MOU's between DIMIA and the states with reference to detention centres are 'in the process' of being developed.

As Sharon Pickering[138] showed in her NSW study, the community welfare sector was having to pick up the pieces in this area. Since that study many states and territories have extended service provision eg providing accommodation support and providing guidelines for refugees in public hospitals. It still leaves asylum seekers, TPV's and Bridging holders as second class citizens where they have to explain their situation again and again.

FEDERAL-STATE RELATIONS BROUGHT TO BEAR IN AREA OF CHILD PROTECTION

Dr.Sarah Mares and Dr.Jon Jureidini[139] in their paper on their study of 10 families in a remote IDC, state that federal/state tensions are brought into focus by health and child protection concerns of the children studied. All of them are known to state child protection services. They quote a chapter of Layton's Child Protection Review on Children in Detention. Layton outlines how the Minister of Immigration is the guardian of minors. The State has legal responsibility to investigate child protection concerns and must then make recommendations to the Federal Government. But the Federal Government can reserve the right to act, or not act on any recommendation. Layton notes that

> ' The State has no jurisdiction to require the release of a child's family from the detention centres in order to ensure the best interests of the child This release can only be achieved with the co-operation of the Federal Minister'[140]

Layton quotes Justice Bhagawati, Chairman of the UN Human Rights Committee who notes that the Minister for Immigration is both the 'detainer' and the 'guardian' which represents a serious conflict of interest.. The Judge further notes that the current memorandum of understanding between state and federal governments does not recognise the serious systemic abuse of children in detention and that most serious abuse does not come from individuals, but arises from the circumstances of detention itself'. Recent cases before the Family Court of Australia have explored jurisdictional areas of responsibility and power in relation to care and protection of children in Immigration Detention.

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[138]Dr Sharon Pickering 2001: She undertook a study of TPV's to show how they had to rely on community agencies for survival. (See earlier reference)

[139] Mares & Jureidini 2003 Children & Families referred from a remote IDC. Available School of Psychiarty, Univ. of NSW.

[140] Layton R. 2003 Children in Detention, in *Best Investment: A State Plan to Protect & Advance the interests of children*. Chap. 22 p22 quoted in Mares & Jureidini ref 139www.dhs.sa.gov.au/childprotection

Mares and Jueidini [141] conclude:

> 'the infants, children and adults described in their study live on our soil but are outside the structures that protect citizens from dehumanising indefinite incarceration, ongoing traumatisation and particularly for children, exposure to violence in a developmentally impoverished environment'.

The consistent picture coming out of all the sources of evidence is a stalemate between DIMIA and the contractor for detention centres on the one hand and the health and mental health services under state jurisdiction on the other. Recommendations by outside professionals are ignored and there seems to be minimum cooperation by the detention centre management at the best and obstruction and resistance at the worst to the point where nothing happens in the interest of detainees.

[141] Mares & Jureidini 2003 see above

ALTERNATE SYSTEMS FOR ASYLUM SEEKERS[142]

No European state has a mandatory non-reviewable detention policy for unauthorised arrivals. Most countries in western Europe initially place asylum seekers in processing centres for a very limited amount of time ranging from 48 hours to three months[143]. Unless there are concerns for national secutity, asylum seekers are then released.

SWEDEN

Sweden's case is interesting because it receives similar numbers of asylum seekers as Australia despite having half the population[144]. Also it held an inquiry to examine detention policy following numerous hunger strikes, suicide attempts and a hostage incident in the detention centres which private companies then managed[145]. As a result of this inquiry, **the management of detention centres was placed within government responsibilities under the Department of Immigration**. Since then the incidence of self-harm has fallen and there have been no major incidents of violence. The main features of their system are as follows[146]:

- Three categories of detention for asylum seekers.[147]
- No child under 18 can be held in detention for more than 3 days. In extreme circumstances this can be extended to 6 days(Swedish law).
- There are no barbed wire around detention facility. It looks like the medical centre next door. It is however fitted with locks and alarms and detainees only have access to inner part of building.
- Individual detainees share rooms but have their own keys to the room. Visitors have access during the day.
- Detention centres employ people from a range of cultural and professional backgrounds including social workers and social anthropologists, counsellors and mental health professionals. One person is employed to organise recreational activities for detainees.
- All detainees are given a caseworker whose primary role is to inform them of their rights and ensure they are upheld in detention. Asylum seekers are kept informed about the procedures relating to their visa application or deportation procedures.
- Staff are regularly given training in relation to refugee law, human rights, discrimination and occupational health and safety.
- Non-government organisations and religious clergy have unrestricted access to asylum seekers and are able to provide feedback to detention centre management. The media has open access to the detention centre.
- For hospital admission of medical or dental appointments two caseworkers accompany the detainee without the use of any restraints.
- In cases of extreme depression where staff are concerned the detainee may attempt suicide, detainees are taken directly to the psychiatric emergency ward or caseworkers are stationed in the detainees room in shifts during the night. A mental health professional speaks with them during the day and may prescribe anti-depressants.

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[142] Refugee Council of Australia prepared from UNHCR pubs. Detention of Asylum Seekers in Europe 1995. www.refugeecouncil.org.au/alternativeEurope.htm accessed April 2000 in Alliance Submission

[143] As above

[144] Alliance Submission p 50

[145] Mitchell, G Asylum seekers in Sweden August 2001. www.refugeecouncil.org.au/alternativeSwede.htm accessed April 2002, in Alliance Submission

[146] taken from the Alliance Submission

[147] cat 1 asylum seekers held minimum 2 weeks, maximum 2 months for identity checks. Cat 2 asylum seekers requiring further investigation or if deemed a security risk. Detention minimun 2 and maximum 4 months. Cat 3 for asylum seekers who are to be shortly deported. Max 2 months usually for duration of travel document preparation

- Once a week detainees meet with their caseworkers to discuss changes in policy at the detention centre, and to discuss concerns and make suggestions. Detention centre staff consider the feedback on a weekly basis and the manager of the centre is present at those meetings approximately once per month. Formal complaints can be lodged by detainees, either directly to the Director or Supervisor of the Centre, or directly to the Immigration Department's Asylum Bureau.
- Once released, asylum seekers are placed in Refugee Reception Housing and can then choose to either stay there or move in with friends or family in the community while waiting a decision.
- Approximately one half of asylum seekers live in government –funded housing while their applications are being processed. The government provides monthly allowances to asylum seekers without any means of support. Asylum seekers whose applications are expected to take longer than four months may receive work permits.
- The Swedish Board of Integration sponsors language training, job placement and housing programs

UNITED KINGDOM

Despite having more rigid policies in relation to asylum seekers than the rest of Europe, the United Kingdom does not place all unauthorised arrivals in mandatory detention for unlimited periods of time.

Those asylum seekers not in detention have access to National Health services by right. This does not mean that access is without problems but if they do reach the service they do not have worries about payment.

Rosemary Nairn
early May 2005

APPENDIX 1

EXTRACTS FROM PROFESSIONAL MEDICAL ORGANIZATIONS POSITION STATEMENTS

Australian Medical Association (AMA)

The AMA's current position statement,1998 deals with '*Health Care of Prisoners and Detainees'*. It is being updated to provide an individual focus on detainees and will be available for their April Federal Council Meeting.

It provides guidelines about the medically harmful nature of solitary confinement; health screening; regular health review; harm minimisation; hunger strikes; persons with psychiatric disorders; suicide prevention and young people. In order to obtain more specific feedback on the issues arising in health care for ex-detainees in the community the AMA is conducting a survey of community based medical staff.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP)

The College's position statement #46 states the principles which should apply to Asylum Seekers and mentions particular concerns about the detention of children and children born in detention, the effects of detention on their subsequent development and upon the functioning of their families. The College has tirelessly advocated for children in detention centres because of the damage they believe was happening to them

Louise Newman their chairwoman said she and others tried to see 'the woman in Baxter' [Cornelia Rau] as recently as December 2004. They were denied permission as she had not asked for an outside assessment. 'But obviously she was psychotic and incapable of making such a request. Her situation was deteriorating rapidly in the conditions in which she was being kept. It is of enormous concern that her acute psychotic condition was to all intents and purposes ignored by the management of the detention centre'(SMH 5/2/05).

The Australian Nursing Federation (ANF)

The Federation in its position statement makes amongst others the specific point,

> 'children should only be detained for a maximum of 6 days and then released with their principal carer into the community. They add 'detention centres should be in metropolitan areas where appropriate services including health care can be provided'.

External scrutiny of detention centres should be enhanced to assist with identifying where internationally agreed minimum standards of detention are not being met.(extract from ANF position statement 2005)

The Royal Australian College of General Practitioners (RACGP)

The College states that access to appropriate health care is a basic human right and that a review and development of health care policies and standards of health care delivery for all refugees and asylum seekers is necessary. The College has considerable concern that the detention of asylum seekers for prolonged periods of time contributes to further psychological and physical health problems for the individuals concerned. The College supports the Alliance of Health Professionals concerns about the health of asylum seekers and their children and with the recommendation that children not be held in anything other than minimal detention for processing purposes only. The College strongly supports the position taken by the Committee of Presidents of Medical Colleges(CPMC) that public accountability and monitoring health status of asylum seekers in detention centres is a priority in Australia today and that contractors employed by the government meet health care standards. The College is opposed to agreements that restrict the professional independence of medical practitioners attending to the health care needs of those held in detention. These restrictions they explain may not only affect their ability to provide information about their observations on the health of patients in detention centres but may also interfere with their professional and ethical obligations. The College recommends that its members do not sign agreements that compromise their professional independence. The College encourages all undergraduate and post-graduate medical training institutions to include asylum seeker and refugee health in its programs. It recommends the ready availability of medical interpreters both in and outside detention centres(extracts from RACGP position statement on Health Care for Refugees and Asylum Seekers 2005)

Royal Australian College of Physicians

The College has been very active in asylum seeker and refugee policy contributing to the Professional Alliance for the Health of Asylum Seekers and their Children. The College works with the Committee of Presidents of Medical Colleges, RANZCP, AMA, the Mental Health Council of Australia and the Beyondblue National Depression Initiative. It endeavours with these groups to bring to notice the adverse effects of detention on this group of people.

In a May 2003 press release Dr. Jill Sewell, Deputy President of RACP stated,

> 'the harm we are doing to children and young people will remain with them for the rest of their lives - -we have a duty of care to children and young people regardless of whether they are refugees or asylum seekers as Minister Ruddock calls them'

In an earlier press release 18/2/2002 this College called for the removal of asylum seekers (in particular pregnant women and young people) from Manus Island following recent cases of malaria among asylum seekers detained there, and the fact the chloroquine-resistant *falciparum* is endemic on the island in PNG.

Australian Psychological Society (APS) & Professional Alliance for the Health of Asylum Seekers and their Children

The APS endorses the key principles of the Professional Alliance for the Health of Asylum Seekers and their Children, being active members of this body.

- children have a right to protection, from exposure to violence and inadequate or neglectful environments. The integrity of the family unit is vital to optimal child development.
- Separate authorities to take responsibility for detention and duty of care especially the care of children. The workings of these bodies should be independent and transparent.
- universal access to basic health care, medicate, the PBS, education and work rights for asylum seekers regardless of status

Drawn from the National Summit on Asylum Seeker Health Care, Nov.2005.

Summary

All the professional medical, nursing and psychology organisations are opposed to the detention regime due to the damaging impact on individuals, family groups, unaccompanied minors and especially young children and those born in detention. They believe that medical, nursing and psychology workers require independence in their professional roles unfettered by retstrictive agreements with the contracting authority. They want universal access to health care for all asylum seekers in the community regardless of immigration status.

APPENDIX 2

LIVING CONDITIONS IN DETENTION CENTRES

Solitary Confinement

The way immigration detention centres are run is patently punitive. On 4/3/05 the NSW Council of Civil Liberties Julian Burnside QC referred to the unregulated use of solitary confinement. This was noted when the Human Rights Subcommittee[148] visited detention centres. Mr Baird, Mr Price and Senator Harradine's questions elicited that solitary confinement lasted 9 days for 24 detainees in the notorious Julian Block in Port Hedland IDC(not currently in use) with only an hour outside each of those days. No charges had been laid—all actions at the discretion of the manager.

Harassment and Abuse

They were also disturbed by the twice a night waking to check passes, after an incident in the Pt Hedland Centre[149]. and the sheer frustration of the detainees whom they met. The British Home Office has ordered an investigation into reports of asylum seekers being abused by staff at detention centres employed by Global Solutions Ltd., which also runs Australia's detention centres on behalf of the government after a culture of abuse and shame was uncovered by the BBC[150]. There have been continuous complaints about savage beatings and harrassment by guards at Baxter. Complaints from clients that detainees were sworn at by guards, denied access to visitors, families were split up and a gym instructor was sacked after she refused to beat a detainee[151.] Such complaints have been the the subject of countless referrals to the Commonwealth Ombudsman and the Human Rights and Equal Opportunity Commission.

Arbitrary Rules, Deprivations, & Intrusions

At Villawood Sultan and O'Sullivan[152] state that the rules governing daily life seem arbitrary, changing from time to time, and from one detention officer to another. Authorities have instituted room searches, confinement in solitary cells, restrictions in receiving visitors, and obstacles to assessing legal representation or medical care. During a hunger strike in July 2000, all electrical power and water supplies to the cell block where the hunger strikers were residing were cut-off, affecting uninvolved women and children. As a consequence the atmosphere at Villawood led to fear, despondency and frustration There are multiple daily musters and nightly head counts which may occur at 2.00 am and three hours later. The public address system operates from 7.00 am to 9.00 pm.

Dearth of Activities

Overall there is a dearth of activities, resources or educational materials provided by GLC and before them ACM, leaving detainees with long periods of unstructured time. Boredom, aimlessness and apathy are widespread especially amongst those who have been detained for long periods of time.[153]

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[148] Joint Standing Committee for Foreign Affairs, Defence & Trade(FADT)Human Rights Sub Committee Hearing on 8/2/01(transcript)

[149] Joint Standing Committee for FADT transcript 207,208,211214,217 Transcript

[150] ABC *Lateline* 3/3/05

[151] Steve Larkin & Sharon Mathieson 6/11/02 news.com.au

[152] Sultan, A & O'Sullivan 2001 Psychological Disturbances in Asylum Seekers held in longterm detention: a participant-observer account. *MJA* 2001; 175:593-596

[153] see above

Exposure to Harm

The Commonwealth Ombudsman[154](2001) stated then' that the accommodation and monitoring/ care arrangements at IDC's did not come up to, 'what I would regard as a minimal acceptable standard to ensure that those at greatest risk are not exposed to harm'. This changed when because of violence at Woomera the families who were in a compound with 80 single males, were moved to Baxter[155]. Also the Minister had established in the Baxter IDC a separate compound for the Sabean Mandaeans at Baxter and the Residential Housing Project as a response to recommendations from the Ombudsman. In the Four Corners Report[156] it was clear that there was no privacy for those held in the management unit(solitary confinement). Cornelia Rau is alleged by detainees to have been observed in the shower by officers and others held in solitary. There were still by late 2003 continuing concerns about the safety of women and families at the Perth IDC. There were individual complaints listed in this 2002-2003 Annual Report. which according to the Ombudsman 'reflects a lack of responsiveness and imagination on the part of ACM officers'. He was referring to the fact that with thought and simple changes such as the provision of locks, opaque screens, TV and a kettel can give a more protected living area for women.

Property Loss

A significant proportion of complaints relate to property loss when transfers are made from one IDC to another or between compounds.

Difficulty in Access to Telephone, Fax and Mail[157]

Access to communication equipment was often a function of the whim of the officer. These apparently small issues lie heavily on this population who have so little and have no idea of their future.For the most part it seems to reflect a lack of respect for the detainees.

Responsiveness to Complaints May Be a Factor

Interestingly the Office reports that the level of complaint from within an Immigration reception and processing centres (IRPC's) and IDC's can depend on the responsiveness to complaint handling within the centre, or the quality of administration generally within the centre.Not all detention facilites used by DIMIA generate an equal level of complaints. For example no complaints were received in 2002–3 from the Arthur Gorrie Correctional Centre(AGCC) near Brisbane which houses immigration detainees prior to their removal from Australia. Many might think that this is due to detainees not being in a position to complain! Firstly the Ombudsman explains that it is undersirable to hold normal detainees in prisons as such an arrangement blurs the distinction between the different status of detainees and criminals. Having said that he explains the different manner in which this facility is run from detention centres and draws some tentative conclusions arising out of this comparison. The Office notes the availability of individual accommodation, the general cleanliness of the accommodation, the ability of detainees to cook basic meals, internal complaint-handling procedure and by contrast to other IDC's and IRPC's generally higher standards overall in access to medical services. The number of detainees in AGCC at any one time

[154] Commonwealth Ombudsman 2001 Own motion investigation into IDC's

[155] Commonwealth Ombudsman Annual Report 2002-2003 p.54

[156] *ABC Four Corners* Program 5/4/05

[157] Commonwealth Ombudsman Annual Report 2003-2004

is small and the length of stay is generally short[158]. Although this is not a sufficient explanation because of the particular situation of these detainees, the general proposition is useful.

What has definitely not changed for those still held in detention is stated' in the 2001Ombudsman Report[159] is as follows:

> 'The loss of liberty and personal freedom associated with detaining persons in a secure institution is akin to the situation of prisoners held in prisons. However unlike criminals who have been extended the full protection of the law before being incarcerated and who as prisoners are exposed to significant checks and balances which have been built up over time reflecting decisions of the courts and community expectations, immigration detaineed appear to have lesser rights and are held in an environment which appears to involve a weaker accountability framework'.

This is the backdrop for an appreciation of health concerns.

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[158] Commonwealth Ombudsman Annual Report 2002-2003 p 53&54

[159] Commonwealth Ombudsman 2001 Own motion investigation into IDC's p3

APPENDIX 3

HEALTH SERVICES PROVIDED AT IDCS 2001[160]

NB The Commonwealth Ombudsman agreed with the Joint Standing C'ttee on Migration's report 2000 recommending expansion of on-site medical facilities.

Perth

- One GP available on-site at 8 hours per week and on call 24 hours
- One Nurse full time and casual as required and on call 24 hours
- Dental Care as required

On site services: Primary health care, first aid, health education and a mental health nurse.

Port Hedland

- Two GP's one male and one female on-site and on call 24 hours
- Six nurses permanent fulltime and part time 7 days per week and on call
- Visiting psychologist who attends on an as required basis to see detainees
- Dental care as required

On-site services: Primary health care, Health Education and visiting Psychiatrist from Villawood as required.

Curtin

- One full time male GP available on-site and on call 24 hours
- Nurses according to population but 10 including Health Services Coordinator
- Health Services Coordinator for the maximun population 24 hours, 7 days per week
- Dental care as required

On-site services: Primary Health care, Health Education and visiting Psychiatrist from Villawood as required. A Mental Health Nurse is also availble on-site.

Woomera

- One full time female GP and on PT male
- General Practitioner available on-site and on call 24 hours

[160] Commonwealth Ombudsman 2001 One motion investigation into IDC's – appendix.

- Nurses according to the population but 13 including Health Services Coordinator
- Health Services Coordinator for a population of 1,740 available on call 24 hours 7 days.
- Dental care as required.

On-site services: Primary Health Care, Health Education and visiting Psychiatrist from Villawood as required. A Mental Health Nurse is also available on-site.

Maribyrnong

- One male GP with a total of 16 hours per week and on call 24 hours.
- Three nurses permanent part-time and casual as required and on call
- Dental care as required

On-site services: Primary Health care, Health Education and a Mental Health Nurse is also available on-site.

Villawood

- One male & one female GP(the former is a qualified psychiatrist) with a total of 60 hours per week and on call 24 hours.
- Seven nurses permanent FT and PT and casual as required 7 days & on call 24 hours
- Clinical Psychologist FT
- Dental Care as required.

On-site service: Primary Health care, Health Ed. Mental Health Nurse 'shared care' antenatal management.

APPENDIX 4

MEMBERSHIP OF PROFESSIONAL ALLIANCE FOR THE HEALTH OF ASYLUM SEEKERS & THEIR CHILDREN

Chair of the Alliance is Justice Marcus Einfeld.

Australasian Faculty of Public Health Medicine

Australian Medical Association (AMA)

Australasian Society for Traumatic Stress Studies

Australian & New Zealand College of Mental Health Nurses

Australian Nursing Federation(ANF)

Australian Psychological Society(APS)

Australian Society for HIV Medicine

Brisbane Refugee Health Network

Chapter of Community Child Health(RACP)

Centre for Community Child Health, Royal Children's Hospital(Vic)

Committee of Presidents of Medical Colleges incorporating:

- Australian & NZ College of Anaesthetists(ANZCA)
- Australasian College of Dermatologists(ACD)
- Australasian College for Emergency Medicine(ACEM)
- Royal Australian College of General Practitioners(RACGP)
- Royal Australian College of Medical Administrators(RACMA)
- Royal Australian and NZ College of Obstetricians & Gynaecologists(RANZCOG)
- Royal Australian College of Ophthalmologists Inc(RACO)
- Royal College of Pathologists of Australasia(RCPA)
- Royal Australasian & NZ College of Psychiatrists(RANZCP)
- The Royal Australasian College of Physicians(RACP)
- The Royal Australasian & NZ College of Radiologists(RANZCR)
- Royal Australasian College of Surgeons(RACS)

Doctors Reform Society

Medical Association for the Prevention of War

Psychiatry Research and Teaching Unit, School of Psychiatry, University of NSW Public Health Association of Australia Inc.

Queensland Nurses Union

Royal Australian & NZ College of Psychiatrists(RANZCP)

The Royal Australasian College of Physicians(RACP)

APPENDIX 5

CASE STUDY EXAMPLES OF DUTY OF CARE NOT BEING MET PROVIDED BY WAYNE LYNCH NURSE/COUNSELLOR IN WOOMERA 2001[161]

A six year old boy whose mental and physical health had dramatically deteriorated following witnessing 3 major incidents in the compound. I made several recommendations about the need for relocation and psychiatric assessment. I was advised that under no circumstance was I to consult with anyone outside Woomera except for the ACM psychologist based in Sydney.

A 10 year old boy was physically abused on two occasions by guards. After no action was taken against the guards by management, I recommended that it was a case of child abuse and should be reported to Family and Youth Services. I was advised by management that if I did this, I would find myself in a lot of trouble.

A 24 year old detainee was continuously self-harming(slashing, swallowing glass). He had been handcuffed to a bed in a room and required exceptional amounts of IV/IM sedation. Management wanted this to be administered in the compound under nursing observation and would not agree to his release to hospital. Eventually the medical officer agreed with me and were able to force relocation to hospital for appropriate treatment.

A 60 year old woman with neurological deficits was not transferred to hospital upon advice of medical and nursing staff. Management believed that it was psychosomatic. Eventually this detainee was diagnosed as having had a stroke and was transferred to Villawood.

A 50 year old detainee was clinically depressed with serious suicide ideation after the death of his son. A request was made for reloction for psychological assessment and support. This request was denied and the response was,'We will have to manage him here'.

[161] Alliance Submission p 35