CHAPTER 4

Provision of health services to people in detention

4.1 In this chapter the Committee considers the provision of health services to people in the immigration detention network.[269] The Department of Immigration and Citizenship (DIAC) provides health services through its contracted provider, International Health and Medical Services Pty Ltd (IHMS), and also through local hospitals and allied health professionals.

4.2 The Committee notes at the outset that, while this chapter deals with all forms of healthcare provision, it is the provision of mental health care that the evidence most often related, and consequently that received the Committee's keenest focus. This is consistent with the findings in Chapter 5, which examines the impact that detention has on the health of detainees and concludes that the level of mental illness among detainees as the most pressing area of concern.

4.3 This chapter builds on the background set out in Chapter 2, starting with a description of the Detention Health Framework, including some criticisms made of it, before examining evidence relating to the provision of health care in more detail. The chapter also picks up on some observations made in Chapter 3 about the Psychological Support Program, and observations made in Chapter 5 regarding the impact of detention on the mental health of detainees.

The Detention Health Framework

4.4 DIAC's key policy framework for health services for people in immigration detention is the Detention Health Framework.[270] The Framework has been in place since 2007, and a review was conducted in early 2011. A number of recommendations were made to assist the Department to respond to the challenges presented by the current increase in detention population. The Detention Health Advisory Group (DeHAG), whose role is described in Chapter 2, as well as other key stakeholders, contributed to the development of the framework and the recent review.[271]

4.5 The key objectives of the framework are to ensure that

- the Department’s policies and practices for health care for people in immigration detention are open and accountable;

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269 Discussion on health in detention was drawn from DIAC, *Submission 32*, *Supplementary*, and from the Detention Health Framework. The Framework can be accessed at www.immi.gov.au/managing-australias-borders/detention/services/detention-health-framework.pdf

270 DIAC, Detention Health Framework, 2007.

271 DIAC, *Submission 32*, p. 60.

- people in immigration detention have access to health care that is fair and reasonable, consistent with Australia's international obligations and comparable to those available to the broader Australian community; and
- ensure that quality of health services provided to people in immigration detention is assured by independent accreditation.[272]

Criticism relating to the implementation of health service policy

4.6 Criticisms of health service policy implementation relate to both the Detention Health Framework, and to the Psychological Support Program policy (PSP).

4.7 DeHAG remains dissatisfied with the implementation of the Detention Health Framework, its Chair, Professor Louise Newman, advising the Committee during the Melbourne hearing:

> DeHAG has provided a submission outlining our central concerns about this psychological impact of prolonged detention, difficulties in provision of health and mental health support, and services across the immigration system. We would like to stress that in our view there has been a significant failure in implementation of current policies which we were involved in developing, which could potentially reduce the risk of the mental damage that we are seeing across the system at the moment—specifically the psychological support policies and policies related to survivors of torture and trauma.[273]

4.8 Particular problems that DeHAG have identified relate to the provision of mental health services, and include difficulties that IHMS has in meeting the psychological needs of detainees and of having independent reviews of complex cases in the system. In relation to DIAC, DeHAG expressed concerns about DIAC's reviews of the system of mental health screening, identification of detainees at risk, and identification of how best to assist them.[274]

4.9 The evidence the Committee received from a former IHMS employee, which is recounted in some detail later in this chapter, also goes to seeing inconsistencies between the objectives set out in the Framework, and the 'on the ground' experience in centres.

4.10 The Psychological Support Program (PSP) policy was developed by DIAC in consultation with DeHAG, IHMS, Serco and other stakeholders. The PSP sets out the actions that IHMS, DIAC and Serco will take to assist and manage people in detention with mental illness. The phased implementation of the PSP was completed in November 2010. Unfortunately the policy had not been implemented in Villawood

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272 DIAC, *Submission 32*, p. 60.

273 Professor Louise Newman, Chair, Detention Health Advisory Group, *Proof Committee Hansard*, 18 November 2011, p. 1.

274 Professor Louise Newman, Chair, Detention Health Advisory Group, *Proof Committee Hansard*, 18 November 2011, p. 1.

IDC at the time of the three deaths in late 2010, which were subject to an inquiry by the NSW Coroner.

4.11 DeHAG described the PSP Policy as best practice:

> I think the PSP policy is what we would see as best practice. It looks at risk reduction. It does not support the old practice, which is of isolation and observation in a very direct way. The evidence suggests—and this is evidence from prison studies and from a whole range of mental health facilities—that that can make people more anxious and worse. It actually advises re-engaging people. You might need a content area. It advises staff not to isolate people in that way and to maintain contact with them, and it gives them some basic strategies.[275]

4.12 However, the Committee heard that there is a disconnect between the PSP, a policy document which apparently represents best practice, and the implementation of that policy by Serco, who are responsible for running the detention facilities on a daily basis.

International Health and Medical Services' role in health care

4.13 International Health and Medical Services (IHMS) is DIAC's contracted health services provider. For people detained in immigration facilities, most primary health services are provided onsite by IHMS. Referrals are made to external health services providers in the community as clinically required.

4.14 Emergency and acute care is provided by local hospitals. For people in community detention and immigration residential housing, health care services are provided exclusively by community-based health providers.

4.15 DIAC signed two contracts in January 2009 with IHMS to provide general and mental health services to people in immigration detention.[276] One contract is for services on mainland Australia, the other is for health services on Christmas Island. Transition from the previous health contracts was completed in May 2009. Unlike the contract with Serco, the contract with IHMS does not contain an abatement system to penalise the company for underperformance.

4.16 The two IHMS contracts were recorded on AusTender as worth $293 million, although this amount varies as changes are made.[277] In 2011, a new contract was entered into with IHMS to replace the two earlier contracts and to provide more support to detainees, including more psychiatric care.[278] From 31 March 2012 all health services will be provided under the *Health Services Contract*. The value of the

275 Professor Louise Newman, Chair, Detention Health Advisory Group, *Proof Committee Hansard*, 18 November 2011, p. 9.

276 Health Services Contract 2009. Question on Notice.

277 Mr Ken Douglas, First Assistant Secretary, DIAC, *Proof Committee Hansard*, 16 August 2011, p. 28

278 DIAC, answer to question on notice, Q296 (received 15 March 2012).

contract is now estimated to be $769.3 million. The Department has requested additional mental health services to be provided on a temporary basis, the history behind this decision is discussed in more detail below.[279]

4.17 IHMS is contracted to provide health services to detainees at the standard available in the general Australian community. Emergency and acute care is provided by local hospitals and specialists.

4.18 Under the Health Services Contract, IHMS is required to meet particular accreditation standards, which were developed by the Royal Australian College of General Practitioners, and form part of the Detention Health Framework. The four types of health services that IHMS is required to provide to detainees are:

- health assessments and screening;
- identification and treatment of communicable diseases;
- general health care services; and
- mental health services.[280]

4.19 The mission statement for IHMS provides:

> IHMS will provide a level of healthcare to people in immigration detention consistent with that available to the wider Australian community, taking into account the diverse and potentially complex health needs of people in detention.
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> These services will be provided in a professional manner that is clinically appropriate, without any form of discrimination, with appropriate dignity, humanity, cultural and gender sensitivity, and respect for privacy and confidentiality.[281]

4.20 DeHAG have raised persistent and serious concerns about the ability of IHMS to provide adequate services to detainees within the bounds of the contract. Professor Louise Newman gave evidence during the Melbourne hearing that in her view to improve the services provided to detainees – particularly in relation to mental health – the service contract required amendment.[282] In particular, DeHAG questioned the ability of IHMS to provide adequate health services to people who continue to be detained, even against professional advice. Professor Newman described the situation of people being treated at hospital for a mental illness, and then returned to detention. The impact of this policy is serious:

> The irony of the current situation—even though IHMS might be attempting to improve service provision, which I think is a very positive thing—is that, within the system of prolonged restrictive detention, people's mental health

279 DIAC, answer to question on notice, Q296 (received 15 March 2012).
280 DIAC, *Submission 32*, Supplementary, p. 61.
281 IHMS, *Submission 95*, p. 4.
282 Professor Louise Newman, Chair, Detention Health Advisory Group, *Proof Committee Hansard*, 18 November 2011, p. 6.

> is unlikely to improve significantly. Even if we threw in there another 1,000 mental health workers, be they psychologists or psychiatrists, we would still have a crisis which is a broad, systemic crisis.[283]

4.21 The contract is also limited insofar as IHMS is not funded to provide paediatric services to children. DeHAG informed the Committee that they had sought to remedy this, but has been unsuccessful thus far.[284]

Health assessments and screening

4.22 All detainees receive a health assessment when they enter immigration detention and when they depart immigration detention. The initial assessment includes taking a personal and medical history and conducting a physical examination and mental health screening. IHMS has incorporated advice from DeHAG about the appropriate approach to be taken when conducting this assessment, particularly with children. At this stage early identification and referral may occur for detainees affected by torture and trauma.[285]

4.23 IHMS coordinates the management and treatment of any health issues that are identified (this will sometimes result in referral, for example, for Torture and Trauma to the local hospital on Christmas Island). Regular monitoring and screening also occurs once a detainee has entered detention, for example, regular mental health checkups every three months.

4.24 IHMS conducts a discharge health assessment for each person who leaves immigration detention. IHMS prepares a health discharge summary that documents relevant health history, treatment provided and any ongoing treatments.[286] Where appropriate, linkages are made with relevant community health providers to facilitate ongoing care beyond discharge.

4.25 While children certainly receive health screening, DeHAG believes that this is not consistent with general standards in the community of paediatric practice. Professor Louise Newman explained the concern, and the problems with getting an appropriate response from IHMS:

> We have recommended the screening of any children who enter into the detention system in terms of their health and development, as would happen in the general community related to the standards of paediatric practice. We have raised that with the department. We have formulated a policy and an outline of what that would involve in a way that it could be implemented in, hopefully, a reasonable way across the system. We have discussed it with IHMS. We have been told that, because it is not a contractual arrangement

283 Professor Louise Newman, Chair, Detention Health Advisory Group, *Proof Committee Hansard*, 18 November 2011, p. 2.

284 Professor Louise Newman, Chair, Detention Health Advisory Group, *Proof Committee Hansard*, 18 November 2011, p. 2.

285 DIAC, *Submission 32, Supplementary*, p. 60.

286 DIAC, *Submission 32, Supplementary*, p. 60.

> between the department and IHMS, it cannot occur. Yet we have a detention health framework, which we were involved in formulating, looking at basic standards of care.[287]

4.26 DeHAG advised the Committee that it had raised this issue with DIAC, and as of November 2011, had not received a response.[288] The problem is exacerbated by the terms of the contract with IHMS.

Communicable diseases

4.27 IHMS screens all people who enter immigration detention for communicable diseases, such as syphilis, tuberculosis (TB), hepatitis B and hepatitis C. DIAC advised the Committee that:

> The incidence is very low, despite high numbers of arrivals, and is generally representative of the populations from which people originate or the country in which they have lived before arriving in Australia.[289]

4.28 DIAC advises that when a communicable disease is identified or suspected it is IHMS' responsibility to work with local public health authorities to manage the disease. For example, quarantining the individual and providing appropriate treatment. The committee received further assurances on this point during hearings.[290]

General health care services

4.29 IHMS is required by the contract to provide primary health care services on-site. These services include a general practitioner, nurse, counsellor and psychologist. IHMS coordinates health care for people in community detention through practices based in the community. Where further services are identified as clinically required (for example, psychiatry services), IHMS refers the detainee to external or tertiary health providers.

4.30 The Committee heard that general healthcare services provided by IHMS were of a good standard, thanks not only to IHMS but also to locally provided health services, on whom detention facilities often rely for acute care. Having said that, a limited number of facilities have 24-hour paramedic services on hand, due to their remoteness. Others do not, and rely instead on a restricted clinic service during the day, with only telephone assistance out of hours. [291]

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287 Professor Louise Newman, Chair, Detention Health Advisory Group, *Proof Committee Hansard*, 18 November 2011, p. 2.

288 Professor Louise Newman, Chair, Detention Health Advisory Group, *Proof Committee Hansard*, 18 November 2011, p. 4.

289 DIAC, *Submission 32, Supplementary*, p. 62.

290 Mr John Moorhouse, Deputy Secretary, DIAC, *Proof Committee Hansard*, 9 December 2011, pp 38–39.

291 Ms Helen Lonergan, Director of Nursing, International Health and Medical Services, *Proof Committee Hansard*, 7 September 2011, p. 11.

4.31 Indeed, rather than the quality of general care provided, it was this hours of operation issue that elicited most concern. The service that IHMS provides at each facility varies according to local conditions and the needs of the detainee population. For example, IHMS runs a 24 hour paramedic/overnight nursing service at Christmas Island, Scherger IDC and Curtin IDC. In all other facilities, IHMS staff work a day shift, and any issues that emerge outside this period are dealt with by a telephone service attended to by nurses. During the Sydney hearing, Mr Ian Gilbert reminded the Committee that the contracted service was building around a primary healthcare at a community equivalent standard.[292]

4.32 In practical terms, what this means is if a detainee is injured in a serious way during business hours, then the detainee will receive first aid care from IHMS and then be transferred to a local hospital. If the injury occurs outside of these hours, then it would be incumbent for a Serco officer to call 000 to report the injury and obtain assistance.

4.33 IHMS advised that while the contract was flexible enough for a 24 hour service to be provided, the arrangements had been developed with a community model in mind:

> If you go back to the original philosophy of the contracted service, it was very much around primary healthcare at a community equivalent standard. At a site like Villawood, for example, which was an originally contracted site, that is very much the philosophy in play. And you are correct; if there is an incident or a medical question that needs to be asked after hours, then we do have a telephone service that is answered by nurses.[293]

4.34 Mr Gilbert also said that:

> It is stipulated in the contract that they are not only in accordance with the timeframes as stipulated by the document itself but also to offer a community equivalency level of care. But in saying that there is also a capacity to extend and be flexible. That is an ongoing dialogue that could happen locally on the ground between the local management teams to extend hours, if it is a short-term requirement. Or equally, through discussion with our Canberra colleagues, to adjust the service delivery model more permanently.[294]

4.35 The New South Wales Coroner's Report on three deaths at Villawood in 2010 highlighted the risks inherent in having a clinic only during week days. Mr Josefa Rauluni received notice on Friday, 17 September 2010 that his recent request for Ministerial intervention (to allow him to remain in Australia) had failed

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292 Mr Ian Gilbert, General Manager, International Health and Medical Services, *Committee Hansard*, 5 October 2011, p. 60.

293 Mr Ian Gilbert, General Manager, International Health and Medical Services, *Proof Committee Hansard*, 5 October 2011, p. 60.

294 Mr Ian Gilbert, General Manager, International Health and Medical Services, *Committee Hansard*, 5 October 2011, p. 60.

and he would be removed from Australia to Fiji on Monday, 20 September 2010. IHMS advised DIAC the day before, 16 September 2010, that 'no immediate risk issues are identified' with Mr Rauluni. However, Mr Rauluni committed suicide on Monday, 20 September 2010. The Coroner noted that DIAC's policy is to avoid providing notice of removal to detainees on Fridays, as detainees are usually in 'more than usual distress' when negative decisions are received. However this policy was not followed on this occasion. No assessment of Mr Rauluni was made after he received the negative decision on Friday, indeed he was not able to receive any support from IHMS over the weekend as the clinic was not open.[295]

4.36 Another consequence of IHMS not maintaining a 24 hour, seven day a week service at many IDCs is an increased role for Serco officers in relation to the handing out of medication. This is addressed in detail elsewhere in the report.

Committee view

4.37 The Committee notes that the Australian Human Rights Commissioner recommended in its 2011 Report on Villawood IDC that DIAC should 'require at least a minimal IHMS presence at Villawood IDC twenty four hours per day, seven days per week'.[296] The Committee acknowledges that IHMS is contracted to provide services consistent with the standard available in the general community. However the Committee is mindful that rates of self harm and mental illness amongst people in detention are much higher than in the general community, as discussed in Chapter 5, and that the level of care reasonably required is possibly higher as a consequence. The Committee is concerned that IHMS does not maintain a 24 hour presence in detention facilities that record high rates of self harm or in all centres that are remote.

Recommendation 14

4.38 The Committee recommends that International Health and Medical Services staff be rostered on a 24 hour a day basis at all non-metropolitan detention facilities.

Recommendation 15

4.39 The Committee recommends that the Department of Immigration and Citizenship assess, on a case by case basis, the need for International Health and Medical Services staff to be rostered on a 24 hour a day basis at metropolitan detention facilities.

295 *Findings in the inquests into the deaths of Josefa Rauluni, Ahmed Obeid Al-Akabi and David Saunders*, New South Wales Coroner, 19 December 2011, pp 2–5, 11.

296 Australian Human Rights Commission, *Immigration Detention at Villawood*, 2011, http://www.hreoc.gov.au/human_rights/immigration/idc2011_villawood.html (accessed 5 March 2012).

Mental health services

4.40 IHMS provides mental health services to detainees, or refers detainees to networked community providers. Mental health professionals include registered counsellors, mental health nurses, psychologists and psychiatrists.

4.41 A number of studies, including some commissioned by DIAC, have found a link between restrictive immigration detention and the development of mental health problems.[297] This link is particularly strong amongst asylum seekers and people who have been in detention for more than a couple of months. Such findings are consistent with the evidence received by the Committee, as well as its observations during visits to numerous detention facilities around Australia. [298]

4.42 The Committee received extensive evidence from detainees and advocacy groups that mental health services in detention facilities are inadequate and unresponsive to the needs of detainees. A typical sentiment was expressed by Darwin Asylum Seeker Support and Advocacy Network, who raised concerns about the number of mental health staff working in Northern IDC:

> DASSAN has been informed that there are only two psychologists and four mental health nurses provided by IHMS for asylum seekers detained in the NIDC. Considering that NIDC has a capacity of over 500, which it regularly reaches, we consider that the Government needs to drastically increase the contracted number of IHMS mental health staff in detention centres.[299]

4.43 Remote facilities make the situation even harder to manage. For example, IHMS said that it was very challenging to find a psychiatrist to come out to the IDC at Curtin, and that they were currently only able to obtain services once a month.[300] A mental health services manager has been recruited, and Curtin is being used as a pilot for psychiatric video-conferencing assessments.[301] It is as well such innovative responses were taking place, as the local services are not in a position to offer large-scale assistance. The Committee heard from the Operations Manager of the Kimberley Health Service that local mental health services were operating at capacity.[302]

4.44 The President of the Australian Human Rights Commission (AHRC) expressed concern about how the mental health support needs of detainees are met, particularly because IHMS has a reactive rather than proactive care model:

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297 DIAC, *Submission 32*, *Supplementary*, p. 62.
298 The impact of detention is discussed in Chapter 5.
299 Darwin Asylum Seekers Support and Advocacy Network, *Submission 51*.
300 Ms Helen Lonergan, Director of Nursing, International Health and Medical Services, *Proof Committee Hansard*, 7 September 2011, p. 7.
301 Ms Helen Lonergan, Director of Nursing, International Health and Medical Services, *Proof Committee Hansard*, 7 September 2011, p. 7.
302 Ms Bec Smith, Operations Manager, Operations Manager, Derby Health Service, *Proof Committee Hansard*, 7 September 2011, p. 1.

> In some facilities like Villawood we were disturbed to find that there is no outreach service provided by mental health carers—that is, unless a person self-identifies as someone who might be in need of mental health care they do not receive it. No-one goes out into the detention centre to see whether there are people there showing signs of needing the services of a mental health carer.[303]

4.45 The Committee asked IHMS to respond to the AHRC's concern that there was no outreach service conducted in the IDCs to check that no one with a mental health issue was falling through the cracks. IHMS explained that staff walk through the communal areas in the centres checking on detainees when there has been a distressing incident. Dr Hooper elaborated on IHMS' approach during the Sydney hearing:

> What we have is the principle that we would be comfortable to walk into areas. Certainly when there is an event or an incident one of our responses with Serco and with DIAC is that we would go into communal areas and try to identify anyone who was in distress. In a normal response, we have sufficient guarantees of security and our staff are happy to work with Serco in the areas. If a client wishes to access care, the normal process is they would notify us with a notification form and then we would identify an appointment time for them to come to see us. But we are conscious that that is not going to pick up everybody. Therefore, insofar as security allows, we are walking in the various areas and we are working with the Serco officers on the ground to identify where there is unmet need to be met by actually going to clients.[304]

4.46 During the Christmas Island hearing, local IHMS staff confirmed that they do not go out into the centres checking up on people as matter of course.

> We will provide an outreach as different clinics are set up. As far as walking around, we would tend not to do that. Our focus is at the clinic and...there are so many different ways of being referred and we tend to focus on that.[305]

4.47 Another significant concern of the AHRC was the model of care provision for mental health support: the person with responsibility is not a psychiatrist but instead a nurse or a psychologist. This concern was shared by the psychiatrist that accompanied the AHRC to Curtin immigration detention centre, and by the NSW Coroner.[306]

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303 Ms Catherine Branson QC, President, Australian Human Rights Commission, *Committee Hansard*, 5 October 2011, p. 55.

304 Dr Dick Hooper, Regional Managing Director, International Health and Medical Services, *Committee Hansard*, 5 October 2011, p. 65.

305 Dr Clayton Spencer, Medical Director, International Health and Medical Services, *Proof Committee Hansard*, 6 September 2011, p. 49.

306 Ms Catherine Branson QC, Australian Human Rights Commissioner, *Committee Hansard*, 5 October 2011, p. 55; *Findings in the inquests into the deaths of Josefa Rauluni, Ahmed Obeid Al-Akabi and David Saunders*, NSW Coroner, 19 December 2011, p. 12.

4.48 The Committee asked IHMS to respond to the concerns raised by the HRC. Mr Gilbert emphasised that the model of care provided by IHMS to detainees is a community model:

> Our mental health nurses have access to psychiatric support. We are following the community model. A lot of the cases are manageable by mental health nurses. They are supported on site by general practitioners in terms of prescribing/understanding, and they are supported by a psychiatrist in terms of professional leadership.[307]

4.49 Following questioning from the Committee, IHMS told the Committee that it was working with DIAC to enable more regular visits by psychiatrists. However, it is acknowledged that provision of a very regular service would be out of step with the standard available in the community, particularly in remote areas where the local community do not have access to regular psychiatric support. During the hearing on 5 October 2011, IHMS acknowledged that the needs of people in detention – especially from a mental health perspective – are different from mainstream Australia:

> We are working with the department creating an enabling process that we can have psychiatric support more freely available at our sites. That is a discussion that is going on with the department at the moment. What we are saying is that we do not need a full-time psychiatrist. We just need to make sure that we have access much more freely. Looking across the range of facilities, some of which are in very remote areas and some of which are in metropolitan areas, the need for immediate onsite psychiatric support is qualitatively different. So, that discussion is going on with the department now and that is a constructive discussion. I do not have a timeframe...but that is a discussion that is active at the moment.[308]

4.50 The IHMS submitted a letter sent to DIAC on 26 October 2011 requesting a change in its service model for detainees. [309] The key reasons were:

> An increasing number of clients are prescribed psychotropic medications for extended periods. Although initially these are prescribed by general practitioners a need for specialist review is necessary when treatment has only a partial or no effect.
>
> An ever increasing number of clients with T&T (torture and trauma) history with significant symptomatology (or due to other issues and are at a higher risk for mental state deterioration) with limited coping strategies.
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> An ever increasing number of clients who have been in detention more than 18 months, as per the department's mental health policy a review by a psychiatrist is suggested.[310]

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307 Dr Dick Hooper, Regional Managing Director, International Health and Medical Services, *Committee Hansard*, 5 October 2011, p. 61.

308 Dr Dick Hooper, Regional Managing Director, International Health and Medical Services, *Committee Hansard*, 5 October 2011, p. 61.

309 International Health and Medical Services, *Additional Information* (received 4 November 2011).

4.51 The Committee is pleased to note that the Department agreed to fund to temporarily this request in December 2011, but concludes that there is much more work to be done to bring mental health services in detention facilities to an acceptable level.[311]

Evidence from a former IHMS psychologist

4.52 The Committee received evidence from a former IHMS psychologist who was employed to provide services to detainees on Christmas Island in 2010. The Committee accepted the submitter's request for the name to be withheld. The submitter was the only psychologist employed during the time, and was part of a multidisciplinary mental health team that provided services to 1800 detainees. The Committee is grateful for this evidence as it provides an insider's account of the provision of mental health services.

4.53 The Committee heard that the submitter did not receive an induction or orientation and workspaces were so crowded that there was not sufficient access to a computer or work station.[312] More significantly, the submitter was surprised that she was not required to provide proper psychological services, only counselling, and that sessions needed to be for less than 50 minutes.[313]

4.54 IHMS advised the Committee that it had formed a multidisciplinary team to respond to the health needs of detainees, and particular services such as Torture and Trauma counselling were provided by the Indian Ocean Territories Health Service:

> IHMS, under the Health Services Contract, is responsible for primary and mental health services and the co-ordination of specialist and allied health services externally. Referral services are utilised by IHMS where appropriate and a client requires a higher level of care, including referrals to psychiatrists, specialists and public health services. On Christmas Island, torture and trauma counselling, for example, is conducted by the Indian Ocean Territories Health Service (IOTHS), which has an appropriate team equipped to cater for this need.[314]

4.55 The three monthly mental health checks were also identified as problematic. Detainees who were due for a check would have their name listed on a noticeboard in English under the hearing 'Mental Health', no time was given and the detainees were expected to turn up at the clinic. The psychologist reports that she was permitted only

310 International Health and Medical Services, *Additional Information* (received 4 November 2011).

311 This is funded as a temporary amendment to the Health Services Contract. DIAC, answer to question taken on notice, Q296 (received 15 March 2012).

312 Name withheld, *Submission 154*, p. 1.

313 Name Withheld, *Submission 154*, pp 2–3.

314 International Health and Medical Services, *Response to Submission 154*, p. 3.

15 minutes for each check and any issues that arose were not to be dealt with at that time but referred to another appointment.[315]

4.56 IHMS responded that mental health services were in high demand, and to ensure that all detainees who were in need access the service:

> [T]here is an emphasis on efficiently delivering services so all members of the client population can receive the attention and care they need. In order to achieve this there needs to be a balance and a value for time management, so all clients can receive treatment when needed. IHMS complements these services and demands with the use of external specialists as required.[316]

4.57 The submitter also argued that there was a conflict of interest because IHMS viewed DIAC as the client, not the detainees. This constrained the psychologist's ability to advocate on behalf of her clients, or to speak directly to DIAC or Serco staff.[317]

4.58 IHMS responded that people in detention are clients, in accordance with the Government's Detention Key Values and the Health Services Contract:

> The work undertaken by IHMS for these "clients" is, of course, carried out in accordance with the terms of the contract executed with the Commonwealth. For the purpose of staff within the Immigration Detention Facilities these are the clients they attend to on a daily basis.[318]

4.59 The concern about conflict of interest has also been expressed by DeHAG. The Chair of DeHAG, Professor Louise Newman explained:

> I think the net result of some of these concerns is that the professional bodies—and this has been raised as well by all our groups and by the medical colleges and the AMA—are deeply concerned about the compromising position of professionals working within the system and the ethical dilemmas that this raises. Many of our member organisations are concerned that the professional people working within the system—be they psychologists, mental health nurses or psychiatrists—are intrinsically being compromised in that the system militates against them providing care in the way that they would expect to practise it. In fact, professionally, in terms of our ethical obligations—these are international standards of practice—we feel that currently it is very difficult to practise at the appropriate level.[319]

4.60 The submitter explained other challenges of treating people in detention, observing that the treatment model was more akin to a psychiatric hospital setting:

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315 Name Withheld, *Submission 154*, p. 7.
316 International Health and Medical Services, *Response to Submission 154*, p. 3.
317 Name Withheld, *Submission 154*, p. 3.
318 International Health and Medical Services, *Response to Submission 154*, p. 3.
319 Professor Louise Newman, Chair, Detention Health Advisory Group, *Proof Committee Hansard*, 18 November 2011, p. 2.

> It seemed that the model of service was based on a model of mental health often applied to a psychiatric hospital setting. This is a setting where patients have been admitted usually following a crisis and have been diagnosed with a psychiatric/mental illness and have usually had some experience with mental health services prior to being admitted. Also, under this model of service, rates of recovery from mental illness without long (or indefinite) courses of drug therapy are notoriously low.[320]

4.61 The Committee believes that the 'on the ground' experience in detention centres is at time inconsistent with the ideals set out in the Detention Health Framework. The psychologist pointed out that an immigration detention centre is not a psychiatric hospital, but has some of the characteristics of one. This was not appropriate for people who required:

> [A] client-centred, preventative model of care, with community interventions, focussing on fostering and maintaining a sense of safety in the centre (where possible) and empowerment for the individual through both psychological treatment and institutional operations and procedures, so that it was part of their everyday experience.[321]

4.62 IHMS rejected this characterisation of its mental health service, explaining to the Committee:

> It should be noted there is no correlation between the model of mental health care provided in the Immigration Detention Network and that which is provided in an institutional setting or in a public hospital. The provisioned health services, including mental health services, are equivalent to those which are available to members of the general community. IHMS does not operate services following an institutional model, a stance which is encouraged by the Health Services Contract with the Commonwealth.[322]

4.63 The psychologist acknowledged that the mental health services were good at identifying mental illness, however staff were not trained or funded to prevent mental illness:

> At some point in an effective psychological intervention, you need to move beyond responding to immediate risks and actually deal with the problems that cause the self harm.[323]

4.64 The Committee invited IHMS to respond to the psychologist's criticism of the mental health service model. IHMS acknowledged that the demand for mental health services had increased over the past 18 months, and advised that it had been working collaboratively with DIAC to meet the growing needs of detainees.[324]

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320 Name Withheld, *Submission 154*, p. 4.
321 Name Withheld, *Submission 154*, p. 4.
322 International Health and Medical Services, *Response to Submission 154*, pp 4–5.
323 Name Withheld, *Submission 154*, p. 6.
324 International Health and Medical Services, *Response to Submission 154*, p. 4.

4.65 IHMS pointed out that DIAC has strong audit controls in place to ensure compliance with the contract. In addition to this it considered itself responsive to DIAC's request for assistance to comply with external oversight. [325]

Committee view

4.66 The Committee is concerned that IHMS is funded to provide a reactive rather than proactive mental health care model. IHMS staff do not routinely walk through IDCs to check up on the general detainee population. Rather, they wait until a detainee self identifies as having difficulty, or until Serco or DIAC refer a person. The Committee believes that given the vulnerability of many people in detention, and the increasing rates of mental health issues, IHMS should adopt a proactive approach to care. This is consistent with recommendations by the Australian Human Rights Commission.

4.67 To this end, the Committee is pleased that since 2010 there have been a number of reforms to the IHMS treatment model and that DIAC has recently negotiated an expansion of psychiatric services to detainees.

4.68 The Committee also recalls its observations in Chapter 3, relating to proper implementation of the PSP Policy, and the need to synthesise it with Serco's co-existing Keep Safe policy, and reiterates the importance of the related recommendations in achieving significant improvements in mental health care in detention. In Chapter 5 the Committee details the adverse impact that detention has on the mental health of detainees and notes the large number of studies conducted in Australia and overseas that substantiate the link between detention and mental illness.[326] The Committee believes that it is crucial that adequate mental health services are provided to people held in immigration detention, and that IHMS should be proactive in providing this service.

Recommendation 16

4.69 The Committee recommends that the Department of Immigration and Citizenship work with International Health and Medical Services to pilot regular mental health outreach services in detention facilities.

Provision of health services in remote communities

4.70 As the Committee travelled around the country, conducted site visits and held hearings, it received evidence of the challenges faced by DIAC, Serco, IHMS and others when providing health services in remote communities. The Committee also heard from local hospitals who provide acute and emergency care to detainees. Generally, the Committee found that IHMS and local hospitals had a close working

325 International Health and Medical Services, *Response to Submission 154*, p. 5.

326 DIAC, *Submission 32, Supplementary*, p. 62.

relationship. However, concerns were raised that people with mental health issues in remote communities might not have those needs adequately met.

4.71 The President of the Human Rights Commission, the Hon. Catherine Branson QC, told the Committee:

> We are anxious to recognise that those who work with IHMS, the people we have met, seem anxious to do the very best they can for the people who are in their care. But we believe that particularly in the remote facilities the level of medical services is inadequate and the level of mental health services in particular is inadequate.[327]

4.72 DeHAG is concerned that people with complex health needs in remote immigration facilities may not have those needs met.[328] This is because of the difficulty in providing adequate health care, but also the impact that remoteness can have on a detainee's mental health. Further, people in remote facilities are disconnected from social and family groups:

> It should be noted that separating individuals from their families and from normal social interactions for prolonged periods is clearly also a risk factor for psychological health problems.[329]

4.73 IHMS agreed that the remote location of some detention facilities created challenges for the organisation. For example, workers needed to be sourced who were happy living in remote communities, part time workers would need to be flown in and out, the size and quality medical facilities in the centres varied and emergency services provided by the local hospital were sometimes under pressure.

4.74 Ms Helen Lonergan, the Director of Nursing for IHMS at Curtin IDC explained the particular challenges experienced by her staff:

> The working environment at Curtin has been challenging to date due to its remoteness, harsh environment and also the rapid population growth. Until recently, staff accommodation shortages have meant that we have not been able to deploy adequate numbers of staff. Also, we have had restricted clinic space, and that has been a very difficult work environment. However, in the past month we have been able to obtain 20 additional accommodation spaces within the community and we have recruited more staff. Also, the working conditions will improve somewhat very shortly with the provision of a more adequate health facility. We refer clients to Derby emergency care, but we are constantly mindful to minimise the impact it has on the public health system and the community.[330]

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327 Ms Catherine Branson QC, President, Australian Human Rights Commission, *Proof Committee Hansard*, 5 October 2011, p. 55.

328 Detention Health Advisory Group, *Submission 41*, p. 3

329 Detention Health Advisory Group, *Submission 41*, p. 3

330 Ms Helen Lonergan, Director of Nursing, International Health and Medical Services, *Proof Committee Hansard*, 7 September 2011, p. 7.

4.75 DIAC agreed with IHMS that Curtin IDC presented particular challenges because of its remoteness. DIAC found it difficult that Curtin was located so far from Derby, and also struggled to recruit staff.[331] Specialist health services are challenging to source due to the remoteness of Derby, resulting in detainees being sent to Perth or Broome for treatment.[332]

Locally provided health services

4.76 Through arrangements made by and paid for by DIAC, detainees who require acute or emergency care are referred to local health care providers by IHMS. The costs associated with this service are billed to IHMS, who then recover the cost from DIAC. In addition, some state and territory local health services receive additional funding to meet overhead costs and additional staffing requirements.[333] These arrangements have been made by DIAC through in-principle agreements or Memoranda of Understanding (MOUs). The Department is currently revisiting all arrangements and working on updated MOUs that reflect current arrangements and requirements.[334]

4.77 The Committee received evidence from local health service providers on Christmas Island, Darwin, Curtin and Weipa. With the exception of Darwin all these health services are provided to remote or regional communities. The potential impact on local communities by a detention population was considered carefully by the Committee. Areas for improvement have been identified, particularly in relation to IHMS' relationships with local healthcare providers and the need for MOUs. However, the Committee was satisfied overall by the close cooperation between IHMS and local providers. The Committee tested concerns that the detention population was adversely impacting on local communities. The Committee believes that on the whole arrangements have been put in place to lessen the impact on local health services.

4.78 As the Committee travelled around conducting hearings, it was assured that detainees are not given priority over other people in the local community. All people who present at the hospital are treated according to triaging processes that consider urgency and need. As Ms Chalmers, from Country Health South Australia, submitted:

> I believe that, in terms of the treatment they receive, they are prioritised in the same way. However, this is a formal arrangement between the state and

331 Mr Greg Kelly, First Assistant Secretary, DIAC, *Proof Committee Hansard*, 7 September 2011, p. 12.

332 Ms Helen Lonergan, Director of Nursing, International Health and Medical Services, *Proof Committee Hansard*, 7 September 2011, p. 7.

333 DIAC, *Submission 32*, p. 79.

334 DIAC, *Submission 32*, p. 79.

> the government to ensure that there is activity based remuneration for these patients.[335]

4.79 The Committee was also concerned that the presence of detainees in small communities might adversely impact on waiting lists for inpatient surgery. In relation to Mount Barker Hospital, the Committee was advised this was not the case:

> The dominant services we have provided have been birthing, where we definitely do not have a waiting list; antenatal and postnatal care, which is provided in accordance with good practice; and allied health services.[336]

Christmas Island

4.80 The provision of health services on Christmas Island presents unique challenges, given its extreme remoteness and obvious lack of ground access. On Christmas Island the Indian Ocean Territories Health Service (IOTHS) provides services to the local communities of Christmas Island and Cocos (Keeling) Islands. A MOU is being developed between the Department of Regional Australia, the IOTHS and DIAC. In practice, the IHMS and IOTHS have a working relationship on the ground.[337]

4.81 The IOTHS provides torture and trauma counselling to detainees and additional services when referred by IHMS. During the hearings on Christmas Island, Dr Julie Graham explained to the Committee:

> On a day-to-day basis we do not have regular contact with the detention services. Our health service provides X-ray facilities, we provide pathology services, we provide in-patient care and we provide psychological services from a trauma and torture team on referral from IHMS.[338]
>
> [We] get people who are requiring inpatient care and we get a mix of general medical, so people with heart conditions, infections, pneumonias. We get clients with orthopaedic injuries–broken bones–that may need referral to the mainland for surgical improvement. We get surgical cases: so, people who have general conditions seen in mainland populations.[339]

4.82 Where members of the community or detainees have medical needs that cannot be met on the island, they are flown to Perth for treatment. The IOTHS explained that the there had been an increase demand for services in the past two years, both from the detention population and the local community:

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335 Ms Helen Chalmers, Chief Operating Officer, Country Health South Australia, *Proof Committee Hansard*, 15 November 2011, p. 15.

336 Ms Helen Chalmers, Chief Operating Officer, Country Health South Australia, *Proof Committee Hansard*, 15 November 2011, p. 16.

337 Dr Julie Graham, Director, Public Health and Medicine, Indian Ocean Territories Health Service, *Proof Committee Hansard*, 6 September 2011, p. 47.

338 Dr Julie Graham, Director, Public Health and Medicine, Indian Ocean Territories Health Service, 6 September 2011, p. 46.

339 Dr Julie Graham, Director, Public Health and Medicine, Indian Ocean Territories Health Service, 6 September 2011, p. 49.

> Our general practice presentations are up 30 per cent compared to two years ago. Our A&E presentations are up 80 per cent. About six months ago we looked at the counselling requirements of people coming through, and generally two to three consultations a day were related to psychological aspects. That covered both community members and staff out at the centre, and was to deal with changes in community. Any change creates stress, and so we were looking at across-the-board mental health aspects. We have actually identified that with the department and at the moment are looking at engaging another psychologist on-island as a community based psychologist.[340]

4.83 The IOTHS gave evidence that although the number of admissions to the hospital had increased, the hospital usually only ran at 30 or 40 per cent capacity.[341] Aside from increased mental health services, which the IOTHS was working on, generally other services were not adversely impacted by the centre.[342] Dr Graham did observe that the changes that the detention facilities have had on the island had resulted in an increased need for mental health services by the local community:

> Certainly, when you look at any environment and at a small environment like this, change provides stress, and communication or lack of communication provides stress. The facilities within the health service are generally quite good. We do not have mainland capabilities. We are not a mainland facility. The communication side of what is going on, what is happening within the detention services, what is happening within the community—that is one complaint. We get a lot of from community members that they do not know what is going on within the centre, within the service, within the community. As I said, the mental health aspect has been highlighted, and we are working on that. We have put in another medical scientist to cope with the load from a laboratory perspective.[343]

4.84 The Committee notes that the tragic sinking of SIEV221 off the shores of Rocky Point in late 2010 may also have contributed to the increased need for mental health services.

Derby

4.85 Derby Health Service is part of the Western Australia Country Health Service (WACHS) in the Kimberly. The Derby Health Service of course provides services to people in remote communities. Ms Bec Smith explained to the Committee the service provided to detainees:

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340 Dr Julie Graham, Director, Public Health and Medicine, Indian Ocean Territories Health Service, 6 September 2011, p. 49.

341 Dr Julie Graham, Director, Public Health and Medicine, Indian Ocean Territories Health Service, 6 September 2011, p. 53.

342 Dr Julie Graham, Director, Public Health and Medicine, Indian Ocean Territories Health Service, 6 September 2011, p. 54.

343 Dr Julie Graham, Director, Public Health and Medicine, Indian Ocean Territories Health Service, 6 September 2011, p. 54.

> Generally WACHS, Kimberley, come into contact with clients from the Curtin detention centre accessing a number of services but most commonly through referral to our medical officers and specialists for more complex investigations or treatment unable to be provided by IHMS staff or on-site at Curtin; emergency treatment by our emergency departments; diagnostic pathology as referred by IHMS staff; diagnostic radiology as referred by IHMS staff; and the ambulance transfer of clients from Curtin to Derby.[344]

4.86 As Derby is a remote community, the Committee was particularly interested in any particular pressures placed on the local health service as a result of the IDC. The Committee heard that the detainee population put additional pressure on ambulance, specialist and mental health pressures.

4.87 In relation to ambulance services, Ms Smith explained the impact that the IDC had on the local health service, particularly in relation to ambulance services:

> The main continued issues that WACHS, Kimberley, are facing are to do with our ambulance transport. Each ambulance transfer or call-out to Curtin detention centre is a 90 minute call-out. We run that ambulance service from our emergency department, where it takes a nurse and an orderly out of the hospital for 90 minutes. Since the opening of Curtin we have had about 60 ambulance calls. We have had conversations with IHMS and DIAC to provide a patient transport system for the less acute. We still accept that we need to do the priority 1 acute ambulance calls, but would appreciate assistance with ambulance transfers of non-acute to lessen the burden.[345]

4.88 Specialist services also presented difficulties. Given the remote location of Derby, specialist services were already in high demand, however, the needs of the detainee population exacerbated this pressure.[346]In relation to mental health services, the health service was already operating at capacity, so any further referrals from the IDC was challenging.[347]

4.89 The health service explained that both it and the IHMS had learnt from past experience to improve the services that are provided to detainees. Following an incident in January 2011, that was not handled well, procedures were put in place between IHMS, Serco, DIAC and the local health service. Ms Smith explained:

> Following that event I believe there was great communication between the service providers, IHMS, DIAC, the hospital and Serco, in terms of how we would manage that better the next time. There was another voluntary

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344 Ms Bec Smith, Operations Manager, Derby Health Service, *Proof Committee Hansard*, 7 September 2011, p. 1.

345 Ms Bec Smith, Operations Manager, Derby Health Service, *Proof Committee Hansard*, 7 September 2011, p. 1.

346 Ms Bec Smith, Operations Manager, Derby Health Service, *Proof Committee Hansard*, 7 September 2011, p. 1.

347 Ms Bec Smith, Operations Manager, Derby Health Service, *Proof Committee Hansard*, 7 September 2011, p. 1.

> starvation event in April and that was handled exceptionally well. Each agency had learned to work together and we had a better outcome from the April event. The regional director had submitted a letter, I believe around March after the first suicide, prompting communication between IHMS and DIAC to increase their psychiatric services on site because we were unable to provide additional services for them.[348]

Committee View

4.90 The Committee recognises the pressures that emergencies at remote detention centres such as Curtin IDC and Christmas Island place on local ambulance services. The Committee believes that DIAC should work with its contracted service providers to develop a transport capability for non-acute injuries.

Recommendation 17

4.91 The Committee recommends that the Department of Immigration and Citizenship develop a transport capability to transfer detainees with non-acute injuries to remote hospitals.

IHMS external support and scrutiny

4.92 All the staff used by IHMS maintain appropriate specialist medical training appropriate to their roles. Additionally, IHMS provides induction training to staff that covers:

- IHMS company background and mission statement
- Immigration detention values
- Delivery of services
- Site specific information, including the profile of the detainee population
- Health information systems
- Clinical management and oversight; and
- Interactions with the Department and Serco.[349]

4.93 IHMS provides an ongoing education program. For example, senior staff participate in peer support and professional development conferences four times a year.[350]

4.94 IHMS staff have access to an employee assistance program, that includes free counselling:

348 Ms Bec Smith, Operations Manager, Derby Health Service, *Proof Committee Hansard*, 7 September 2011, p. 2.
349 International Health and Medical Services, *Submission 95*, p. 3.
350 International Health and Medical Services, *Submission 95*, p. 3.

> We offer our staff an employee assistance program. All our staff are given the name of an external provider that they can access 24 hours a day. After any major event there would be a debriefing of that event as well. Sometimes—for example, at the Christmas Island riots—we have sent counsellors to the island for our staff. We had them there for a period of time so our staff could access them whenever they felt they needed to talk to them.[351]

Auditing

4.95 Both IHMS and DIAC have commissioned or conducted audits of the delivery of health services to people in detention. In addition to the quarterly audit of health and medication records, IHMS has arranged for four audits to occur:

> During 2009: Internal audit against the RACGP standards conducted by IHMS head office personnel at a number of facilities.
>
> April 2011: Internal audit at Christmas Island facilities against RACGP standards conducted by IHMS head office personnel.
>
> May-Jun 2011: A detailed audit of the management processes and governance of health services, commissioned by IHMS and conducted by International SOS (parent company).
>
> June 2011: Each site conducted a self-assessment against the RACGP Standards[352]

4.96 The Department has commissioned four reviews.

- Review of Health Service Delivery Model Christmas Island, completed in June 2010
- Review of Health Service Delivery Model Mainland Detention Facilities, completed October 2010
- Royal Australian College of General Practitioners (RACGP) Accreditation Pilot, completed October 2010
- Review of Christmas Island Detention Health Services Clinical Governance Processes, completed May 2011[353]

4.97 The Committee has not had the opportunity to assess these reviews, and so cannot comment on any findings or recommendations made. However, the Committee believes that DIAC is taking an active role in reviewing the standard of health services delivered to people in detention.

4.98 The Commonwealth Ombudsman, Australian Human Rights Commissioner and DeHAG also have an oversight role.

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351 Ms Helen Lonergan, Director of Nursing, International Health and Medical Services, *Proof Committee Hansard*, 7 September 2011, p. 11.

352 DIAC, answer to question take on notice, Q106 (received 17 November 2011).

353 DIAC, answer to question take on notice, Q106 (received 17 November 2011).

Conclusion

4.99 The Committee believes that in all the circumstances, provision of general medical services to detainees is adequate. Likewise, the Committee considers that DIAC is working well with local health care providers to ensure that detainees receive acute and emergency care that is consistent with the standard available in the local community.

4.100 Local providers are doing an excellent job providing services to the detainee populations and have developed good working relationships with IHMS and DIAC officers based locally. The Committee is pleased that through co-operation, communication, and a fee-for-service model, services to local Australians do not appear to be adversely impacted by the presence of immigration detention facilities.

4.101 Nevertheless, as outlined above, the Committee does believe that some improvements can be made, particularly in relation to ambulance services in remote communities such as Derby and Christmas Island.

4.102 However, the Committee's view of mental health service provision is very different. Indeed, from evidence presented to it through submissions and at hearings, and from the Committee's observations at numerous site visits, it is clear that acute mental illness is widespread across the detention network. It is equally apparent that mental health services are severely inadequate to deal with the quantum and severity of cases, and that urgent improvement is required.

4.103 To this end, the Committee is aware of recent enhancements to DIAC's contract with IHMS, including a substantial expansion in the number of mental health professionals available to offer treatment, and hopes that these will result in better mental health support for detainees.[354]

4.104 In the final analysis, however, the Committee is sympathetic to Professor Louise Newman's view that no matter how many mental health professionals are made available, an elevated level of mental illness in detention settings is probably inevitable.[355] It is to the effect of detention that the Committee now turns its attention.

354 DIAC, Question on Notice, 29 February 2012 (received 15 March 2012).

355 Professor Louise Newman, Chair, DeHAG, *Proof Committee Hansard*, 18 November 2011, p. 2.