SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

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The Secretariat
Senate Legal and Constitutional References Committee

Re: Inquiry into the administration and operation of the Migration Act 1958

Dear Sir / Madam,

I attach a submission to your current *Inquiry into the administration and operation of the Migration Act 1958*, prepared by Dr Mitchell Smith, Director of The NSW Refugee Health Service, unit of Sydney South West Area Health Service (SSWAHS).

Further inquiries about the submission can be addressed either to Dr Smith on 02 8778 0770 or to Dr Greg Stewart, Director of Population Health, Planning and Performance on 02 9828 5773. Dr Smith and Dr Stewart would be available to appear before the Committee if called.

Yours sincerely

for Professor Diana Horvath AO
Chief Executive

Date: 11/8/05

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NSW Refugee Health Service

Submission to the

Senate Legal and Constitutional References Committee's

Inquiry into the administration and operation of the *Migration Act 1958*.

August 4 2005

Prepared by:

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Summary

The NSW Refugee Health Service is funded by the NSW Department of Health to protect and promote the health of refugees, and others of refugee-like background, residing in that state. To this end the service acts to build the capacity of health workers and health services across NSW to adequately address the health needs of refugees, and also runs specialised services and projects targeting these individuals and families.

As one of the peak bodies in NSW responsible for providing and supporting appropriate health care to refugees, the NSW Refugee Health Service welcomes the opportunity to make a submission to the Senate Inquiry. The Service recognises the recent changes made by the Department of Immigration and Multicultural and Indigenous Affairs in attempting to provide a considered and compassionate response to refugees and asylum seekers in Australia. However, a number of matters are worthy of further consideration.

This submission raises concerns in relation to the following areas:

- Health screening and protocols for people arriving to Australia through the off-shore refugee program
- Rural and regional settlement of humanitarian entrants
- Access to health care for asylum seekers living in the community, particularly the application of the 45-day rule relating to Medicare eligibility.
- The standards and delivery of health care for people being detained within Villawood Immigration Detention Centre.
- Procedures for the transfer of health records and ensuring smooth transition of health care for people being released from detention
- Involvement of health staff in forced deportations from Australia.
- Other ethical issues for health staff involved with detainees and others.

The submission includes a number of recommendations that contend to address the issues outlined.

a. ***the administration and operation of the* Migration Act 1958*, its regulations and guidelines by the Minister for Immigration and Multicultural and Indigenous Affairs and the Department of Immigration and Multicultural and Indigenous Affairs, with particular reference to the processing and assessment of visa applications, migration detention and the deportation of people from Australia;***

1. Asylum seekers

Key health issues for asylum seekers are often similar to those of refugees arriving through the offshore refugee program, and include: psychological distress; dental disease; under-managed chronic conditions (e.g. diabetes, heart disease); exposure to TB and parasites; nutritional problems; and injuries from war and/or torture. Health care needs may therefore be high. Several studies in Australia have demonstrated asylum seekers to be a highly traumatised population with a high prevalence of depression, anxiety and post-traumatic stress disorder, and that such problems are likely to be worsened by their experiences here.

1.1 Application for asylum and the 45-day rule

A person who arrives on a valid visa and then makes a claim for asylum in Australia can live in the community whilst that application is processed. However, if that claim is lodged more than 45 days after arriving in the country, the person (and family) is denied the right to work and is ineligible for Medicare. They cannot access income support through Centrelink.

In 2002 (last time data provided by DIMIA) there were 5,000 asylum seekers living in the community NSW, with one third of these (ie over 1500 men, women and children) affected by this regulation. The effects include:

- difficulty accessing the most basic health care
- those able to access a fee-free primary care practitioner or service are faced with a bill if any pathology or x-ray is required, and generally cannot afford to be referred to see a specialist
- access to hospital is very difficult, as under Commonwealth-State agreements Medicare card ownership is a proxy for the right to (free) public health care
- no access to PBS-subsidised medications (due to the recently introduced requirement to show a Medicare card at chemists), further prohibiting adequate health care for this group.

Only a small proportion of asylum seekers in the community meet the strict criteria to qualify for medical cost payments through the Asylum Seekers Assistance Scheme (funded by DIMIA and administered by the Australian Red Cross).

The NSW Refugee Health Service sees many patients who fall foul of this arbitrary deadline, as their options for care when unwell are very limited. Other options include charity run organizations or a number of general practitioners, dentists and others willing to see patients for free or for a nominal cost. However such understanding health professionals and services can rapidly become overwhelmed by the need.

Our Service is aware of many cases whereby basic heath care has to be negotiated and multiple attempts made to locate services that are willing to provide health care on a pro-bono basis for vulnerable and highly disadvantaged individuals and families.

> A pregnant asylum seeker woman is told she cannot have routine antenatal care or book in for confinement without paying a large sum of money "up front". She can't afford this, so goes without proper care and presents to the hospital only when in labour.

> A 35-year-old asylum seeker from South Asia was a diabetic. Not having Medicare, he'd had no blood test or any form of health check for 18 months. He has difficulty affording the necessary medication and monitoring equipment, and in accessing practitioners. This increases his risk of complications and shortens his life expectancy.

> A 50 year old requiring long term medication for a serious heart problem relies on medicines provided through donation from a drug company.

There are several broad issues:

- Preventive care/early intervention principles: these underpin sound health policy and practice, and contribute to cost effectiveness. For example, the costs to the health system and the community will be far higher if a pregnant asylum seeker with no antenatal care gives birth to an infant that needs neonatal intensive care.

- Public Health imperatives: depending on the countries of origin and transit, asylum seekers may be at higher risk of certain communicable diseases. Although investigation and management of certain conditions of public health importance is free to everyone diagnosed and treated in NSW (e.g. tuberculosis – NSW Health Dept Circular 99/6), restricted access to GPs and other services means the initial

diagnosis of such diseases may be delayed. This has implications for the community and the patient.

- Moral and humanitarian principles: asylum seekers form part of the community and should have the right of access to health care. The current situation perpetuates inequity. Moreover it creates additional stress to an already traumatised population.

Recommendations

- That asylum seekers living in the community be given work rights and Medicare access until their refugee determination process has been completed.

In the absence of Medicare access:

- ASAS funding be expanded to cover preventive and curative health care costs for anyone in need.
- Asylum seekers be excluded from the requirement to have a Medicare card in order to access PBS priced medication.
- Commonwealth/State agreements on health care provision allow hospitals to provide free care for ineligible asylum seekers on humanitarian grounds.

1.2 Expeditiousness of the on-shore refugee determination process

Related to the above issues, there is concern about the length of time it takes for some asylum claims to be determined. The RHS is aware of one person who accessed the service who had already waited eleven years for his case to be finalised. Some asylum seekers have suffered human rights abuses (e.g. imprisonment without trial, beatings, torture, rape) and been exposed to distressing events. The anxiety caused by uncertainty about their future immigration status and the lack of access to various services and supports compounds existing trauma and impedes any attempt to rebuild a new life. Streamlined decision-making processes would help reduce this burden.

Recommendation

- That measures be undertaken to limit the time taken to finalise asylum applications.

2. Temporary Protection Visa holders

TPV holders have access to Medicare and torture and trauma counselling once released from detention. However, their entitlements to a range of other settlement

services are extremely limited. During a minimum three-year stay they cannot access many Federally funded services, including health programs such as hearing aids or prosthetic appliances. TPV holders are not permitted to have family members join them here in Australia, nor can they leave and return.

There is evidence from specialist health services working with this group, from other state government departments, from community agencies and from academic research that many TPV holders suffer significant psychological distress as a result of the above visa conditions. Many of these people will be granted permanent refugee status and will eventually settle in Australia. Limiting their access to certain health care and other services impairs their well-being.

> A child released from detention on a TPV was assessed as needing a hearing aid. As the National Hearing Program is Commonwealth-funded, he was not eligible for a free hearing aid, as other children are. His parents were unable to afford the cost.

Recommendation

- TPV holders be given access to Federal health care services if required.

3. The Offshore Refugee Program

Whilst health screening is undertaken for all humanitarian arrivals prior to arrival in Australia, this process may be completed up to one year prior to departure. This has implications for health on entry. With the recent (2005) onset of charter flights and other large group departures from refugee camps in Africa, the introduction of pre-embarkation health checks and treatment for certain key conditions is welcomed. Certain gaps in the process remain, however.

Of particular note is the inability to access information about health and health care provided overseas. Whilst provision of immunisation records was standard for Indochinese refugees arriving from camps in the 1980s and 90s, this no longer occurs. The result is duplication of medical care and unnecessary vaccinations for some individuals.

There has been a rapid demographic shift in the refugee quota with 70 per cent now coming from African countries. This presents clients with more complex health needs, lower literacy and poorer English skills. The shift in refugee profile to a largely African one is highlighting a number of previously rare health issues. The Royal Children's Hospital in Melbourne has highlighted the high prevalence of vitamin D deficiency (resulting in clinical rickets), intestinal parasites, anaemia and under-immunisation. Recent arrivals to NSW have demonstrated high rates of malaria, schistosomiasis (or bilharzia, a blood fluke) and the conditions mentioned above. Exotic and unusual health

conditions and patients from cultures widely different from the dominant one here increase the need for upskilling of health professionals.

The burden of providing care and of educating health professionals falls on the state and territory health services. Whilst the intake from Africa is welcomed, there does need to be recognition at Commonwealth level of this burden, and acceptance of a greater lead role in overseeing the response. The notion that refugees are eligible for Medicare and therefore catered for is inadequate: the private general practice setting does not lend itself to health assessments for such high needs, non-English speaking new arrivals with exotic conditions and no financial resources to see other than a bulk-billing or fee-free service.

To enhance coordination and assist with develop national guidelines for the provision of refugee health care, it is proposed that an Australian Government appointed *National Refugee Health Committee* be established. Such a committee would liaise with DIMIA and Commonwealth-State health services and coordinate national approaches to screening and other health interventions for refugees. Membership of this Committee would include health professionals with expertise in the health of humanitarian entrants and with knowledge of the public health systems in Australian states and territories.

Recommendations

- The establishment of an Australian Government appointed *National Refugee Health Committee* that would liaise with DIMIA and Commonwealth-State health services and coordinate the national response to health care for refugees
- Development of a handheld medical record that accompanies an individual from pre-embarkation through the first five years of resettlement.
- A systematic protocol for ensuring adequate immunisation of all refugees arriving through the Offshore Humanitarian program
- A generic letter given to all arrivals that can be taken to the first appointment with a medical practitioner, explaining that they have just arrived and may need to be assessed for a number of specific health issues.
- Evaluation and review of the recent African charter flight pre-embarkation health screening
- Protocols that assist the transition of health care from countries of origin to Australia, including provision of immunisation records.

b. the activities and involvement of the Department of Foreign Affairs and Trade and any other government agencies in processes surrounding the deportation of people from Australia;

Our service is aware of examples of forced sedation ("chemical restraint") of immigration detainees, used in particular to facilitate deportation. This involves administration of a sedating drug by a medical practitioner or registered nurse under their direction. It may be used in conjunction with physical restraint eg. handcuffs, plastic ties.

Medico-legally, a medical act that involves contact with the body without the patient's consent is generally construed as assault. Exceptions are in emergencies e.g. life saving drugs, or where a person through mental illness was so disturbed as to be a risk to either themselves or to others.

However, the Migration Act 1958 (& associated Regulations) provides for the use of "reasonable force" to keep detainees in detention. This can include physical other forms of restraint approved by the Contract Facility Manager and under the guidance of medical staff.

The Human Rights & Equal Opportunity Commission (HREOC) has produced a document *Guidelines for Detention Centres* (March 2000 – available at www.hreoc.gov.au). The following is an extract, with relevant footnotes included, relating to this issue:

"18.8 Chemicals, such as sedatives, should not be applied as an instrument of restraint. An application of chemicals should only be undertaken by a qualified medical or mental health professional who deems it necessary to meet the health needs of the detainee and only for therapeutic or diagnostic purposes.[i] The detainee's consent should be obtained unless he or she is judged, on medical grounds, to be incapable of giving a valid consent.[ii]

[see footnotes end of document]

The regulation apparently does not authorise the Secretary to *require* a medical practitioner to act in a way contrary to his or her ethical, moral or religious convictions. However the dilemma of a practitioner's dual loyalty (to a patient and to the employer) is clear in this setting. The pressure for a nurse to act contrary to his or her professional ethos may be even greater. A recent article in the magazine of the NSW Nurses' Association, *The Lamp (July 2005, pp 30-31)*, highlighted their opposition to nurses being involved in this practice. The Association advised its members to contact the Health Care Complaints Commission in NSW should detention centre management approach them to be involved in forcible administration of medication.

Amnesty International (UK) has raised concerns about this issue in the past, and highlighted several deaths resulting from forcible deportations in Europe (http://www.amnesty.org/, AI index EUR 43/006/2001; 29/6/01).

Recommendation

- That the Migration Regulations 1994 and DIMIA's Immigration Detention Standards be amended to ensure protection of the rights of the individual, and so as not to compromise the professional ethics of health staff employed in immigration detention to care for people detained.

c. The adequacy of healthcare, including mental healthcare, and other services and assistance provided to people in immigration detention;

1. Care in detention

The provision of health care (medical, psychological and dental) within Immigration Detention Centres should be independent, comprehensive and adhere to professional codes of practice.

A number of issues have been brought to light through our interaction with health staff working in Villawood Detention Centre, through liaison with Area Health Service staff dealing with patients from the Centre, and our direct involvement with persons released from detention:

- There are concerns that cost considerations could impact on the level of health care provided. For example, referral to a specialist requires a transport van and two guards to accompany the patient, in addition to the medical costs – in theory, such referrals might be discouraged by management if there were cost concerns. This is most likely to be an issue as isolated IDC sites.
- Confidentiality of medical records appears not to be assured, with non-health staff having potential access to same. These records may contain details of past abuses or psychiatric reports. Personal details such as pregnancy status of women or HIV status have apparently been requested at times by custodial or managerial staff. Similarly, custodial staff at times wait in close proximity to the room where medical consultations are taking place.
- Health staff working in the centre are seen as part of the system, exacerbated by the nurses having to wear uniforms similar to that of custodial staff.
- The inability of doctors to act as advocates for their patients presents a further ethical challenge. They are not allowed to write support letters (e.g detailing psychological or other conditions) for detainees, reinforcing the notion they are part of the detention regime.
- The degree to which informed consent is sought for testing or medical care among a detained population where many individuals have limited English skills is unclear.

Local Area Health Services have in the past been requested by the Centre Management (or the medical organisation contracted to provide health care) to provide certain outreach health services to persons residing within the detention centre in NSW. Generally these requests have had to be turned down due to the ethical and practical complexities of providing care in such a setting.

2. Care in hospital

Issues of confidentiality and autonomy have also been raised by health workers caring for detainees admitted to hospital. The hospital is deemed an "alternative place of detention" in this case, and guards accompany the patients at all times. Guards may forbid access by visitors and have been said at times to monitor access by health staff.

> In July 2003 an Afghan asylum seeker admitted to deliver her baby in a public hospital had visitors turned away by hospital staff, who had been instructed to deny the woman was even there. She was not allowed to receive flowers.
> In the past guards have forbidden photographs to be taken of newborn babies born to women from detention centres, allegedly to protect privacy.

> In December 2004 a five year old girl scraped her knee in the detention centre. The wound became infected. She was eventually admitted to hospital with cellulitis, requiring intravenous antibiotics.
> The girl's father and two guards accompanied her. Her father had no money to pay for meals while he stayed with his daughter.

3. Issues on release

- Medical follow up for those released has in the past been poorly arranged, and in our experience individuals are not provided with written summaries of the health screening or any medical care given in detention. Duty of care principles demand that comprehensive transfer of information occurs on release.
- Public health staff have reported that detainees have been released without proper follow-up of a notifiable disease such as syphilis. Obtaining information on a person's whereabouts after their release is blocked by privacy principles.
- Furthermore, there have been examples of persons with significant health issues released from detention on a Bridging Visa or via *habeas corpus*, yet they are not entitled to access to Medicare. A pre-school aged girl recently released with psychological concerns is an example of this.

Recommendations

- Concerns about resources versus adequacy of care would be removed if health services within IDC's were provided directly by the Commonwealth rather than through a private contractor

- The findings of an independent national body overseeing the delivery of health services in IDCs be available for scrutiny by relevant health agencies and other bodies (eg HREOC).

- Health consultations should be provided with an accredited interpreter where required. All health staff should be trained in the use of interpreters

- Persons in detention should have access to preventive health programs eg immunisation, cervical screening, nutrition education etc

- Confidentiality of all health procedures and records needs to be maintained

- Immigration Detention staff should not be present during any medical consultations, and detainees should be able to access medical services at any time without having to seek permission from custodial staff

- All health staff within Immigration detention facilities should be trained in refugee health issues and in culturally appropriate trauma-sensitive care.

- Handcuffs or other chemical or physical restraints not be used during transport to and from medical or dental appointments.

- Detainees placed in hospital should be under the care of the staff of that hospital. The hospital administration and health staff should take all decisions about their care, visitors and other matters. Custodial staff should only be present to ensure the person returns to the IDC when appropriate.

- On release there is a need for adequate medical documentation, adequate supply of medications if required, and appropriate referral & follow up arrangements. Health staff need to be informed as soon as a detainee is due for release, to allow medical follow-up to be arranged

- All persons being released should be provided with a list of support agencies and other relevant services that may assist them in the community.

d. the outsourcing of management and service provision at immigration detention:

See first two recommendations, previous section.

e. any related matters:

1. Rural & regional settlement

DIMIA policy to settle more humanitarian entrants in rural and regional areas, including to locations not experienced with this form of migration (e.g. in NSW: Coffs Harbour, Lismore, Inverell), is presenting significant challenges to health and other services in those locations. Support and training activities for health staff, and networking and planning meetings with service providers, are a growing need in rural and regional centres with subsequent administrative costs to state health services like our own.

A recent fact-finding visit to the north coast of NSW by the NSW Council of Social Service (NCOSS) found all services over-stretched, with limited coordination and little evidence of pre-planning.

Recommendation

- Increased consultation and planning be undertaken by DIMIA with state and local government services regarding rural and regional settlement of refugees in particular.

2. The Migration Act and medical confidentiality.

Our service has been informed of occasions where certain staff working in public hospitals feel it is their duty to inform the Department of Immigration if they suspect a patient is not legally in the country. This may be based on an erroneous belief that someone without a Medicare card is not here legitimately, and can cause great distress to, for example, an asylum seeker admitted to hospital.

Health service principles generally forbid disclosure of information about a patient to a third party. Exceptions occur, such as when a serious criminal offence is thought to have taken place. It appears the current Migration Act also allows, and indeed mandates, such confidentiality to be breached, if relevant.

Recommendation

- The Act be altered such that patient confidentiality is maintained in all circumstances, and health staff are not confronted with dual loyalty issues pertaining to administrative (not criminal) matters.

Footnotes to page 8

i Principle 5 *Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* stipulates that "It is a contravention of medical ethics for health personnel ... to participate in any procedure for restraining a ... detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the ... detainee himself, of his fellow ... detainees, or of his guardians, and presents no hazard to his physical or mental health": UN Doc. A/37/51 (1982).

ii Rule 55 *United Nations Rules for the Protection of Juveniles Deprived of their Liberty*; Principle 10(1) *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.*"