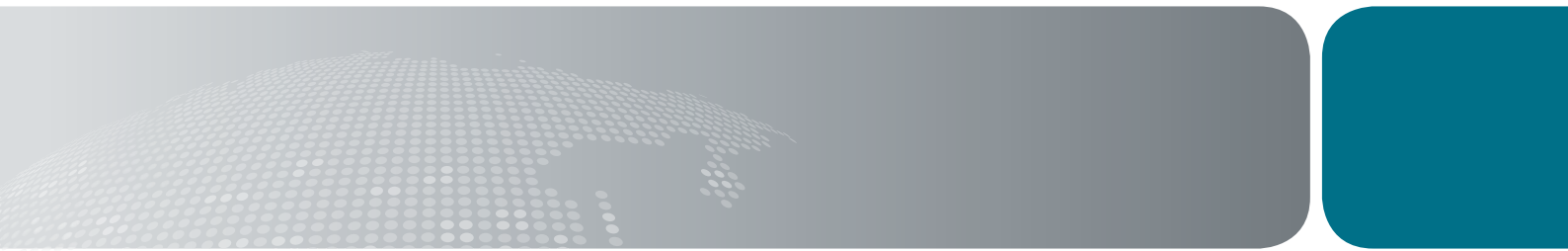




Australian Government
Department of Immigration
and Citizenship

Detention Health Framework

A policy framework for health care for people in immigration detention



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Foreword

It is just over two years since the Palmer and Comrie reports were released. These, and the more than 240 other cases involving immigration detention matters referred to the Commonwealth Ombudsman in 2005 and 2006, have provided the major catalyst for comprehensive business and cultural change in the department. In what the Ombudsman, Professor John McMillan, has described as 'perhaps the largest change program in a central government department that we have witnessed in recent decades'¹, no aspect of my department's operations or people has been untouched.

The key to successful change management, I believe, is not to view the process as merely fixing mistakes but as an opportunity to acknowledge and learn from them, and to be persistent in renewing systems and programmes for the benefit of the community, clients, stakeholders and staff. It is also necessary to create a culture that is accepting of and comfortable with change and is therefore open to self-reflection and continuous improvement. Nowhere is this better reflected than in the programme of improvements described in the Detention Health Framework.

At the time of writing my department is in the process of re-tendering for detention services for immigration detention centres, residential housing and transit accommodation, as well as health care services for people in detention. I would like to make clear that we are not simply re-tendering for the same services. An immense amount of work within the department, informed by significant consultation with a wide range of stakeholders, has resulted in a new service delivery model.

This model not only ensures that those tendering for detention and health care services are aware of their obligations when providing services for people in immigration detention; it provides a range of quality assurance measures, including accreditation against formal health care standards, that will provide independent assurance that the department is meeting its duty of care obligations.

There has already been a great deal of positive change and an enormous amount of work done to set a blueprint for further improvements in the area of detention health, and yet I see the publication of this framework as a beginning rather than a chance to rest on our laurels. The articulation of enlightened policy is one thing; its implementation another. The sustained effort required to achieve the improvements set out in the framework is illustrated most clearly by the Action Plan 2007-2010 (Chapter 10). While some actions are substantially completed, most will require sustained effort over the three-year life of the plan.

In conclusion, I would like to express my thanks to the Detention Health Advisory Group (DeHAG), chaired by Associate Professor Harry Minas. I am particularly pleased with DeHAG's invaluable input to the framework because the group is made up of independent health experts, many of whom have been outspoken in their criticism of the department's management of detention health issues in the past.

Andrew Metcalfe
November 2007

¹ *Lessons for Public Administration: the Ombudsman Investigation of Referred Immigration Cases, Presentation to an Institute of Public Administration Australia Seminar*, Prof John McMillan, Commonwealth and Immigration Ombudsman, Canberra, 6 August 2007 [www.comb.gov.au/commonwealth/publish.nsf/AttachmentsByTitle/speeches_2007_03/\\$FILE/Lessons_IPAA_seminar.pdf](http://www.comb.gov.au/commonwealth/publish.nsf/AttachmentsByTitle/speeches_2007_03/$FILE/Lessons_IPAA_seminar.pdf)

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1 Introduction

1.1 Background and context

1.1.1 A need for change

In July 2005, Mr Mick Palmer delivered his final report to the Australian Government entitled *Inquiry into the Circumstances of the Immigration Detention of Cornelia Rau* (the Palmer Report).² The report identified systemic weaknesses in the Australian Government Department of Immigration and Citizenship's (DIAC) operations that contributed to the length of Ms Rau's detention, the failure to establish her identity and therefore her lawful status in Australia, and the failure to meet her mental health needs. Mr Palmer recommended, and the Australian Government accepted, the need for a wider rethinking of the way DIAC handles its compliance and detention responsibilities. The Palmer Report has become a key driver of the DIAC's reform agenda in these areas.

In September 2005, the Commonwealth Ombudsman delivered his report of the inquiry by Mr Neil Comrie, entitled *Inquiry into the Circumstances of the Vivian Alvarez Matter* (the Comrie Report).³ While the report focused on the way DIAC handled its compliance and removal activities, it contained similar findings to those outlined in the Palmer Report in relation to the need for systemic reforms. In particular, the Comrie Report emphasised the need to use health assessments to ensure that compliance and removal activities are focused on a person's wellbeing as well as an immigration outcome. Again, the Australian Government accepted the recommendations of the Comrie Report and reiterated its commitment to a wide-ranging reform agenda to improve the way that DIAC fulfils its compliance and detention obligations.

Following the Palmer and Comrie reports, the Australian Government asked the Commonwealth Ombudsman to investigate 247 cases where a person had been detained for some period between 2000 and 2007, but later released and their computer record marked with the descriptor 'not unlawful'. The ombudsman's reports found that 11 of these cases involved mental health and incapacity.⁴ While these additional reports reflect largely on past practice, the lessons learned have contributed to future policy development.

In response to the findings of the Palmer and Comrie reports, DIAC has reviewed its detention operations and adjusted its processes and the ways in which detention is managed. In particular, DIAC has improved its staff training, information technology infrastructure and systems, and physical and mental health care for clients.

² www.immi.gov.au/media/publications/pdf/palmer-report.pdf

³ [www.comb.gov.au/commonwealth/publish.nsf/AttachmentsByTitle/reports_2005_03_dimia.pdf/\\$FILE/alvarez_report03.pdf](http://www.comb.gov.au/commonwealth/publish.nsf/AttachmentsByTitle/reports_2005_03_dimia.pdf/$FILE/alvarez_report03.pdf)

⁴ A description of the full range of the ombudsman's reports on immigration detention, and the lessons learned from these, is provided in *Lessons for Public Administration: Ombudsman Investigation of Referred Immigration Cases, August 2007*, report 11|2007 by the Commonwealth Ombudsman, Prof John McMillan, under the *Ombudsman Act 1976*. [www.ombudsman.gov.au/commonwealth/publish.nsf/AttachmentsByTitle/reports_2007_11/\\$FILE/report_2007_11.pdf](http://www.ombudsman.gov.au/commonwealth/publish.nsf/AttachmentsByTitle/reports_2007_11/$FILE/report_2007_11.pdf)

In September 2005, DIAC established a Detention Health Task Force to examine the findings of the Palmer Report as they relate to health care for people in immigration detention. The department circulated a consultation paper describing future needs for improved detention health arrangements to external stakeholders, including the new Detention Health Advisory Group established in response to the Palmer Report. Following consultation, improved detention health arrangements were articulated in a high level statement of intention — the *Future Detention Health Strategy* — which was approved by the Australian Government in May 2006. Under this strategy, DIAC formed the Detention Health Branch to ensure that the reform process would be properly funded and resourced.

On 1 March 2006, the Minister for Immigration and Citizenship announced that DIAC would go out to tender for its detention services contract, in response to the recommendations of external scrutiny processes carried out in late 2005. The minister also announced that a separate contract would be developed to deliver health and psychological services in the detention environment. The separation of contractual arrangements was finalised on 29 September 2006. The main reason for separating these governance and contractual arrangements is to ensure that health care and wellbeing support provided to people in detention is not compromised by the administrative detail associated with security-related legislative requirements.

1.1.2 Nine core operating principles for onshore detention

An important basis for improving immigration detention arrangements was the development of core operating principles for onshore detention. The following nine principles (listed in Box 1.1), endorsed by the Australian Government, were developed in parallel with a commitment to a broader range of detention options, including new housing and accommodation options for people detained under the *Migration Act 1958*. These principles underpin all aspects of this *Detention Health Framework* and are essential for creating an environment that supports wellbeing by influencing factors beyond the control of the health system. They recognise that a high-quality health service does not of itself guarantee good health outcomes; wellbeing is critically dependent on a humane and well-managed detention environment.

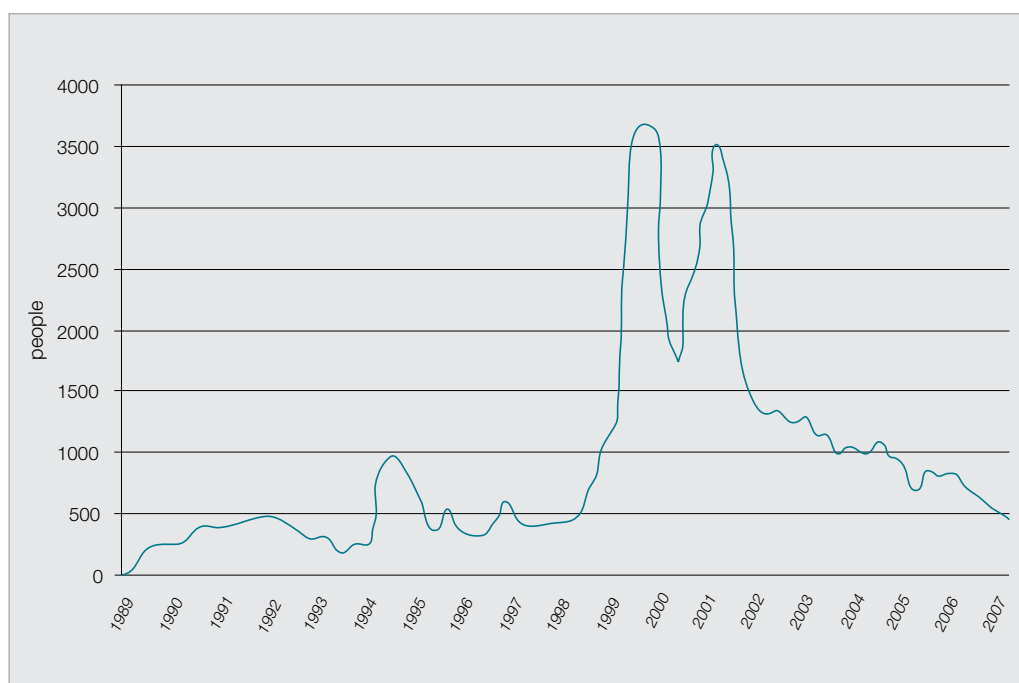
Box 1.1 Core operating principles for onshore detention

1. Immigration detention is mandatory 'administrative detention'; it is not indefinite or correctional detention.
2. People in detention must be treated fairly and reasonably within the law.
3. Detention service policies and practices are founded in the principle of duty of care.
4. Families with children will be placed in facility-based detention only as a last resort
5. People in facility-based detention are to be provided with timely access to quality accommodation, health, food and other necessary services.
6. People are detained for the shortest practicable time, especially in facility-based detention.
7. People are carefully and regularly case-managed as to where they are to be located in the detention services network and the services they require.
8. The assessment of risk factors underpins operational decision making.
9. Detention service operations are subject to continuous improvement and sound governance.

1.1.3 Historical trends in detention numbers

Historically, the size of the population in immigration detention has fluctuated considerably, as illustrated in Figure 1.1, below.

Figure 1.1 Numbers in immigration detention 1989–2007



In contrast to the spikes between 1999 and 2002, the graph indicates that numbers in immigration detention since 2002 have stabilised at much lower levels. The future numbers of people to be held in onshore detention is difficult to predict with certainty, as populations and demographics are subject to rapid changes due to external factors. The potential for future spikes similar to those in 1999 and 2002 is factored into DIAC's planning, which is illustrated by the Immigration Detention Network (described in Chapter 2).

1.2 About the *Detention Health Framework*

1.2.1 Description of the framework

The *Detention Health Framework* describes the principles and practical arrangements that underpin DIAC's improved approach to health care for people in immigration detention. It builds on issues identified in the Palmer and Comrie reports, and the various subsequent reports by the Commonwealth Ombudsman, but goes further in attempting to understand and anticipate issues of health and wellbeing that may be expressed by the different groups of people who may enter immigration detention.

The improved approach described in the *Detention Health Framework* focuses on being more responsive to the needs of people in detention, puts greater emphasis on health risk assessment, and ensures that appropriate health care is accessible for all people across the expanded range of immigration detention arrangements — not just people in centre-based immigration detention facilities. The framework does not deal with ongoing health care for people whose claims for protection are being processed offshore under the care of international organisations. It does, however, cover initial health assessments conducted on Christmas Island.

A cornerstone of the new approach is the development of formal detention health standards that describe the degree of evaluation and service monitoring necessary to ensure that the quality of health services provided to people in detention is comparable to those available to the Australian population.

This *Detention Health Framework* is best understood as an umbrella document that provides an overview of detention health. It is supported by a range of supporting documents that provide detail in specific areas. These include:

- Royal Australian College of General Practitioners *Standards for Health Services in Australian Immigration Detention Centres*⁵
- Immigration Detention Placement Model⁶
- Detention Service Delivery Model⁷
- detention health protocols in the *DIAC Procedures Advice Manual*.⁸

Box 1.2 lists the primary outcomes of the *Detention Health Framework*, and the five objectives necessary to achieve them.

5 Royal Australian College of General Practitioners (2007). *Standards for Health Services in Australian Immigration Detention Centres*, Royal Australian College of General Practitioners, Melbourne

6 Details of the placement model is provided in Section 2.5 The placement process.

7 www.immi.gov.au/about/contracts-tenders/detention-services/_pdf/SDM.pdf

8 Health policies relating to people in immigration detention will be incorporated into the *Procedures Advice Manual 3* during 2008 and made available through DIAC's legislation and policy repository — LEGENDcom. www.immi.gov.au/business-services/legend/about.htm

Box 1.2 Primary outcomes and objectives of the *Detention Health Framework*

Primary outcomes

The primary outcomes of the *Detention Health Framework* are that:

- DIAC's policies and practices in relation to health care for people in immigration detention are open and accountable
- 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
- the quality of health services provided to people in immigration detention is assured by independent accreditation.

Primary objectives

The following five objectives will help to achieve these outcomes:

- Provide a clear description of a full spectrum of health care, from prevention and promotion through to assessment, treatment, discharge planning and integration back into the community, across all immigration detention placements.
- Promote an environment underpinned by the philosophy of shared responsibility for health outcomes by ensuring clients have access to all relevant information about their treatment and care options and are given choice about whether to avail themselves of these options.
- Promote a risk assessment-based health framework that matches health assessments and responses to identified health risk factors, thereby maximising opportunities for early intervention while avoiding subjecting people to unnecessary assessments.
- Promote a health care system based on formal detention health standards that provide a robust foundation to monitor the quality of health service provision in all detention situations.
- Describe the principles for data collection, analysis and reporting to support evidence-based decision making in the detention health environment.

1.2.2 Purpose of the framework

The *Detention Health Framework* articulates a set of principles and arrangements aimed at providing people in immigration detention with access to the health care that they could reasonably expect if they were living in the community. It will provide people in immigration detention with health services that are fair and reasonable, while recognising the physical and psychosocial health risks of being in detention.

The framework serves as:

- an articulation of DIAC's core values of being open, accountable and striving for fair and reasonable dealings with clients
- a focus for ongoing quality improvement
- an educative tool to ensure consistency and integrity of service delivery across the detention health system.

1.2.3 Audience for the framework

The *Detention Health Framework* is a guide for DIAC staff, detention service providers, health professionals and the general community (including community advocates) across the full range of immigration detention facilities and placements in Australia.

1.2.4 Implementing the framework

At the time of writing, DIAC has started a tender process to introduce new contractual arrangements for detention services. Following extensive community and industry consultations, the following three tenders were released in May 2007 for the next generation of detention services:

- *Provision of Detention Services in relation to People in Detention at Immigration Detention Centres*
- *Provision of Detention Services in relation to People in Detention at Immigration Residential Housing and Immigration Transit Accommodation*
- *Provision of Health Services in relation to People in Detention.*

The concepts outlined in this framework underpin the requirements of the *Request for Tender for Health Services for People in Immigration Detention*.

While DIAC expects the new contractual arrangements to be in place in 2008, more time will be required to fully implement the *Detention Health Framework*. The quality of health care for people in immigration detention has improved greatly over the past two years, and many of the principles and processes described in this framework are current practice. However, DIAC recognises that sustained effort over the next two to three years will be required to translate rhetoric into reality; to implement improved policies in ways that achieve real improvements to the subjective experience of people in immigration detention and the staff who work with them. The actions necessary to implement this framework and to achieve continuous quality improvement are described in Chapter 10 (Detention Health Framework Action Plan 2007–2010). Section 8.2 (Effective governance) also contains more information about contractual arrangements for detention services and governance.

2 The immigration detention context

This chapter explains the legal basis of immigration detention and the range of immigration detention placements, and provides an overview of Australia's immigration detention network.

2.1 The basis for immigration detention

Australia's *Migration Act 1958* requires people who are not Australian citizens and who are unlawfully in Australia to be detained. Unless they are given legal permission to remain in Australia by being granted a visa, they must be removed from Australia as soon as reasonably practicable. Immigration detention is not used to punish people.

People can become unlawful non-citizens in a number of ways, for example:

- by overstaying their visa
- by entering the migration zone (the states and territories of Australia) without a valid visa
- by having their visa cancelled.

Unlawful non-citizens are required to remain in immigration detention until their status is resolved, either by granting them a visa or removing them from Australia. This may mean that unlawful non-citizens are held in detention for short periods from 3–4 hours, or longer periods ranging from several days, weeks, months to (in some cases) years.

People who overstay their visas are by far the largest group who become unlawful and most are granted a bridging visa, allowing them to remain in the community lawfully pending their voluntary departure or consideration of an application for a visa other than a bridging visa. People who are granted a visa are released from detention immediately.

Immigration detention is an option of last resort for people while their status as unlawful non-citizens within Australia is under review. It is important to remember that immigration detention is administrative detention, not correctional detention, and that a relatively small percentage of cases result in detention. For example, in 2005–06, compliance located 10 443 people who had either overstayed their visas or were in breach of their visa conditions⁹. Of these, the department detained only 2099 people⁹, or 20 per cent.

Immigration detention plays an important role in maintaining the integrity of Australia's migration, refugee and humanitarian programmes. Australia's mandatory immigration detention policy was introduced in 1992 and has been maintained by successive governments.

The immigration detention policy ensures that people who arrive without lawful authority do not enter the Australian community until their identity and status have been properly assessed and they have been granted a visa, and people who do not have authority to be in Australia are available for removal from Australia.

⁹ Department of Immigration and Multicultural Affairs, Annual Report 2005-06 – Part 2 – Report on performance, Outcome 1 – Effectiveness measures and results, Output 1.3.3 and 1.3.5. www.immi.gov.au/about/reports/annual/2005-06/DIMA_AR/Contents.html

2.2 Offshore entry persons

In 2001, a number of important amendments to the *Migration Act 1958* were passed.¹⁰

The amendments included the necessary powers for dealing with people who arrive in Australia without authorisation, and land in places or installations that are excised from the migration zone. An excised offshore place remains part of the migration zone, but is treated differently from the rest of the migration zone for a person who arrives without a visa. Excised offshore places include the territories of Christmas Island, Cocos (Keeling) Islands, Ashmore and Cartier Islands; Australia's sea installations; and Australian resource installations. Also included are any other prescribed external territories or any island that forms part of a state or territory that is prescribed for these purposes. As of 21 July 2005, the following territories were prescribed and, as a result, are excised offshore places:

- the Coral Sea Islands territory
- all islands that form part of Queensland and are north of latitude 21 degrees south
- all islands that form part of Western Australia and are north of latitude 23 degrees south
- all islands that form part of the Northern Territory and are north of latitude 16 degrees south.

People arriving without a visa in these places are now known as 'offshore entry persons' and are, unless otherwise approved by the minister, barred from making visa applications while they are in Australia and are unlawful non-citizens. Offshore entry persons may be taken to a declared third country, Nauru or Papua New Guinea (PNG), to have any claims for protection assessed (for example, under the United Nations *Convention Relating to the Status of Refugees*¹¹). An offshore entry person who is taken to a declared third country is not in immigration detention under the *Migration Act 1958*.

The scope of the *Detention Health Framework* includes initial health assessments conducted for offshore entry persons on Christmas Island but does not include ongoing health care for offshore entry persons transferred to Nauru or Manus Island (PNG), whose claims for protection are being processed offshore under the care of international organisations, such as the International Organisation for Migration.

2.3 Children in detention centres

In June 2005, the *Migration Act 1958* was changed to state that minors shall only be detained as a measure of last resort. This change, which reflects a statement of principle by the Australian Parliament, relates to holding children in traditional detention arrangements. The principle indicates that where a child must be detained under the *Migration Act 1958*, they should, when and wherever possible, be detained within the community, under residence determination (community detention) arrangements.

¹⁰ *Migration Legislation Amendment (Immigration Detainees) Act 2001, Migration Amendment (Excision from Migration Zone) Act 2001 and Migration Amendment (Excision from Migration Zone) (Consequential Provisions) Act 2001*

¹¹ United Nations (1954). *Convention Relating to the Status of Refugees of 1951*, Treaty Series 189(2545). www.unhcr.ch/html/menu3/b/o_c_ref.htm

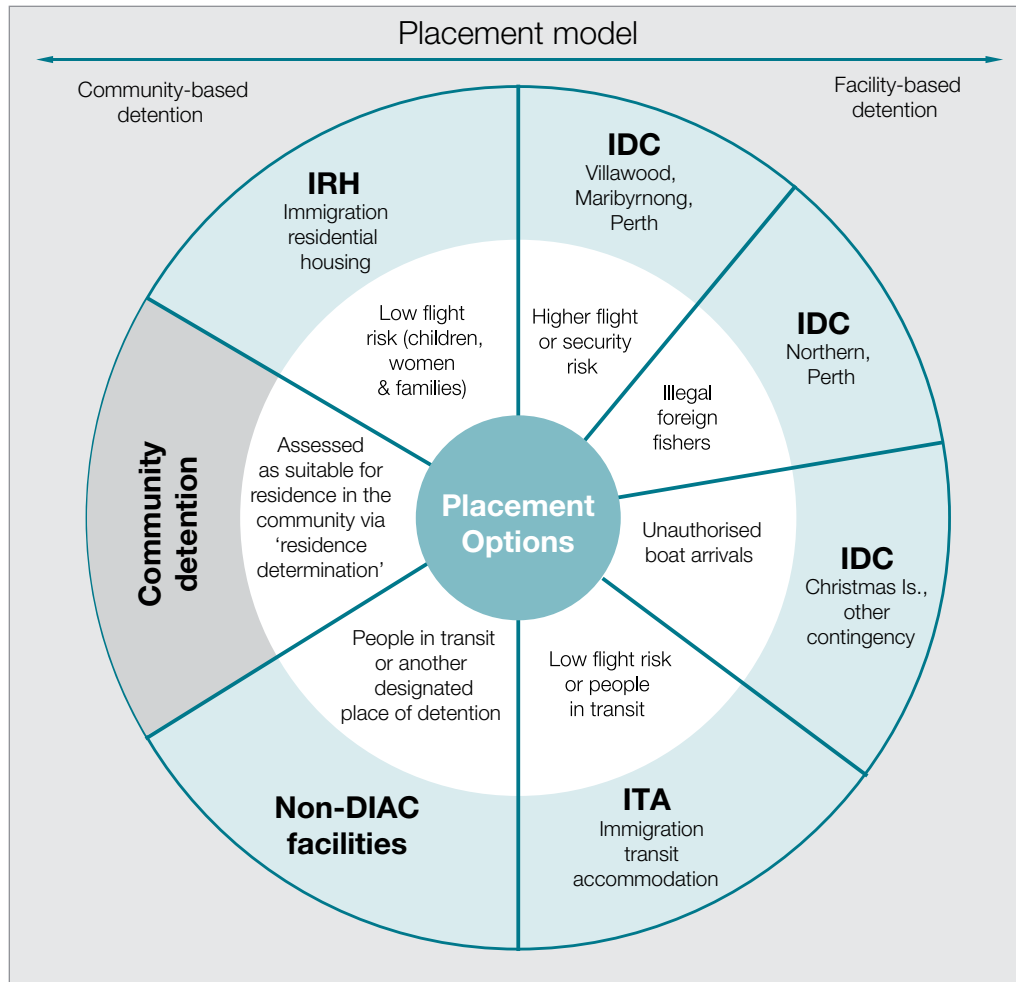
In July 2005, all families with children were moved from centres into community detention. From this date, all families who enter immigration detention are initially accommodated in immigration residential housing or alternative temporary detention in the community, and are referred to the minister for consideration for residence determination (community detention) arrangements within four to six weeks of entering the Detention Services Network. These immigration placements are described below.

2.4 Types of immigration detention

As part of the detention reform agenda, the Australian Government Department of Immigration and Citizenship (DIAC) has broadened the range of detention accommodation options. This provides greater flexibility when choosing the most appropriate detention placement for people in immigration detention.

Figure 2.1 shows the various placement options, including broad guidelines on placement.

Figure 2.1 Placement model



The major types and sub-types of immigration detention placement are described in more detail below.

2.4.1 Immigration detention centres

Immigration detention centres provide a secure environment for people in detention who are of higher flight or security risk than people placed in other immigration detention environments. Families with children are not accommodated in immigration detention centres except as a last resort. Immigration detention centres provide a range of accommodation, including compounds, dorms, single rooms or ensuite rooms. The type of accommodation is chosen according to a person's security and flight risk and broader social and health needs. Dining areas, laundries and multipurpose areas for programmes and activities are shared. Immigration detention centres are securely fenced and have landscaped outdoor areas for recreational use.

2.4.2 Alternative detention

Alternative detention refers to another place of immigration detention approved by the minister in writing under subparagraph 5(1)(b)(v) of the *Migration Act 1958*. There are three sub-types of alternative detention catering to the different needs and risk profiles of people in detention:

- **Immigration residential housing (IRH)**

IRH refers to DIAC facilities that provide a less institutional, more domestic detention environment for eligible people of low flight and security risk. The main priority of IRH is to provide accommodation for families with children, those awaiting a community detention decision and those who have not been granted community detention. IRH may also be used to accommodate other, low-risk people.

- **Immigration transit accommodation (ITA)**

ITA is a form of alternative detention and is a new model of service under development. The main priority of ITA is to provide low-cost short-term transit accommodation (up to seven days) for low security and flight risk people — generally people turned around at Australian airports. It offers semi-independent living in hostel-style accommodation for people with minimal health needs and security requirements. Families with children will only be placed in transit accommodation for short periods.

- **Alternative temporary detention in the community**

Alternative temporary detention in the community is used to address short-term situations where other detention options are either not available or not suited to a person's particular circumstance. It may include motels, apartments and private houses, hospitals and, in some cases, remand or correctional facilities, and provides short-term placement options. Alternative temporary detention in the community, in the form of apartments, is used for families where IRH is either not available or not suitable. It is also used to accommodate people in detention who may have specialist health or physical needs that cannot be met in immigration detention facilities. This form of immigration detention requires the person in detention to be accompanied by an officer or other designated person.

2.4.3 Community detention

Community detention is a form of immigration detention that is authorised by the minister under section 197AB of the *Migration Act 1958*. It allows people in immigration detention to be detained in the community. Community detention does not require the person in detention to be accompanied by an officer or other designated person. The person or family lives in a house, supported by a non-government organisation, in the community with no physical sign of being detained. The main groups who are considered for community detention are families with children, unaccompanied minors and people who have special needs that cannot be met in an immigration detention centre or other facilities. Only the Minister for Immigration and Citizenship has the power to place people in community detention. In a legal context, this form of detention is referred to as 'residence determination (community detention)' because it involves a determination by the minister.

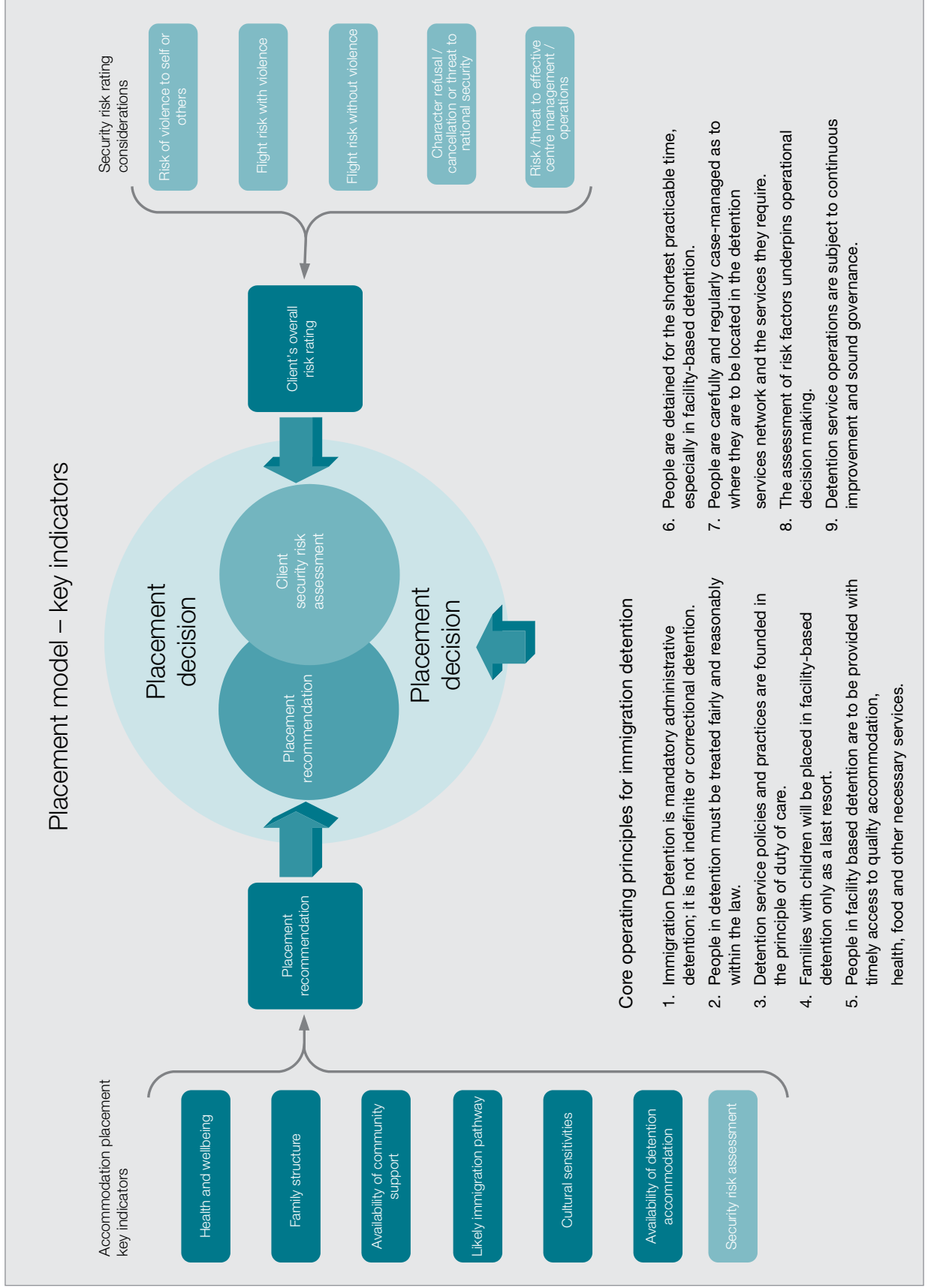
2.5 The placement process

One of DIAC's key strategic themes is fair and reasonable dealings with clients, and to achieve this, the department is implementing an improved client service approach for immigration detention services. In particular, DIAC has developed a new placement model to give greater consideration to a person's individual circumstances when determining detention accommodation placements.

Previously, placement decisions were primarily based on the broad agreed use of detention facilities and the person's risk profile. For example, potential long-term detention placements were routinely placed at Baxter Immigration Detention Facility, and single women or families with children (who volunteered) were placed in Port Augusta IRH. Both of these facilities were closed in August 2007. The new placement model provides a framework governing the transfer, placement and intra-facility movement of people in the detention network. Under the new placement model, placement decisions are based on a detailed assessment of the person's individual needs, balancing the person's specific circumstances with associated risk factors, and the availability of the full range of detention accommodation options.

The placement model acknowledges that a person's preference for placement may not always be met. However, their circumstances will be fully considered and their placement in the network will be managed in a fair, lawful and timely way. The placement model requires detention accommodation placements and movements to be assessed against seven key indicators. These key indicators are outlined in Figure 2.2 and address health and welfare, family, community support, likely immigration pathways, cultural sensitivities, availability of detention accommodation, and security.

Figure 2.2 Placement model — key indicators



Deciding the type of detention placement does not depend on one indicator in isolation, although there may be instances where health or security requirements override the other information in the placement decision. When this occurs, it will be clearly documented. Information against the seven key indicators will be provided by key parties including the Health Services Manager, the case manager, departmental officers and the detention service provider. This information will be used and accessed within the parameters governing privacy and confidentiality.

Generally, DIAC will discuss placement options with people in detention. The department will provide formal advice to people at the start and completion of a placement review, together with the reasons for the placement decision.

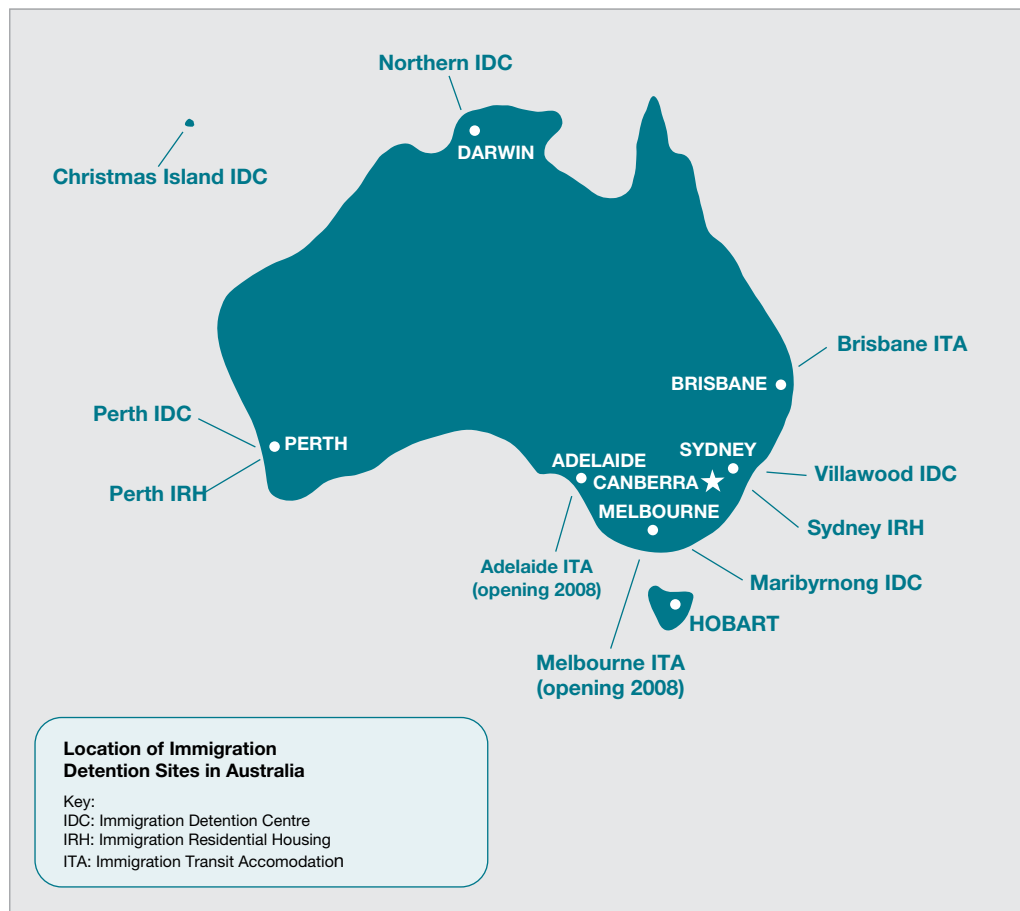
Placement reviews can be requested directly by people in detention and by any key stakeholder. Reviews can also be triggered by specific events, such as significant changes in an individual's health, immigration pathway or risk assessment.

Following a successful trial in 2006, rollout of the placement model across the entire Immigration Detention Network began in mid 2007.

2.6 The Immigration Detention Network

The numbers of people to be held in onshore detention in the future is difficult to predict with certainty, as populations and demographics are subject to rapid changes and external factors. As illustrated in Figure 1.1, the number of people in immigration detention at the time of publication is at an eight-year low, following dramatic peaks in 2000 and 2002. The Immigration Detention Network, shown in Figure 2.3, reflects this volatility both in terms of geographical spread of facilities and latent capacity, which can be brought online to respond to any future peaks in demand.

Figure 2.3 Australia's Immigration Detention Network



3 Current immigration detention caseloads

This chapter outlines who is in immigration detention and provides some indication of detention durations. It does not attempt to explain in any detail how or why people come to be in immigration detention.

3.1 People who are detained

People in immigration detention can fall into two groups, depending on whether they arrive in Australia lawfully (and subsequently become unlawful), or whether they enter Australia unlawfully in the first place. Within these two groups, there are sub-groups as shown in Box 3.1, below.

Box 3.1 Categories of people in immigration detention

Group 1: people who arrive lawfully but become unlawful

People in this group become unlawful because they:

- overstay their visa
- breach a visa condition and have their visa cancelled, including cancellation as a result of criminal conviction.

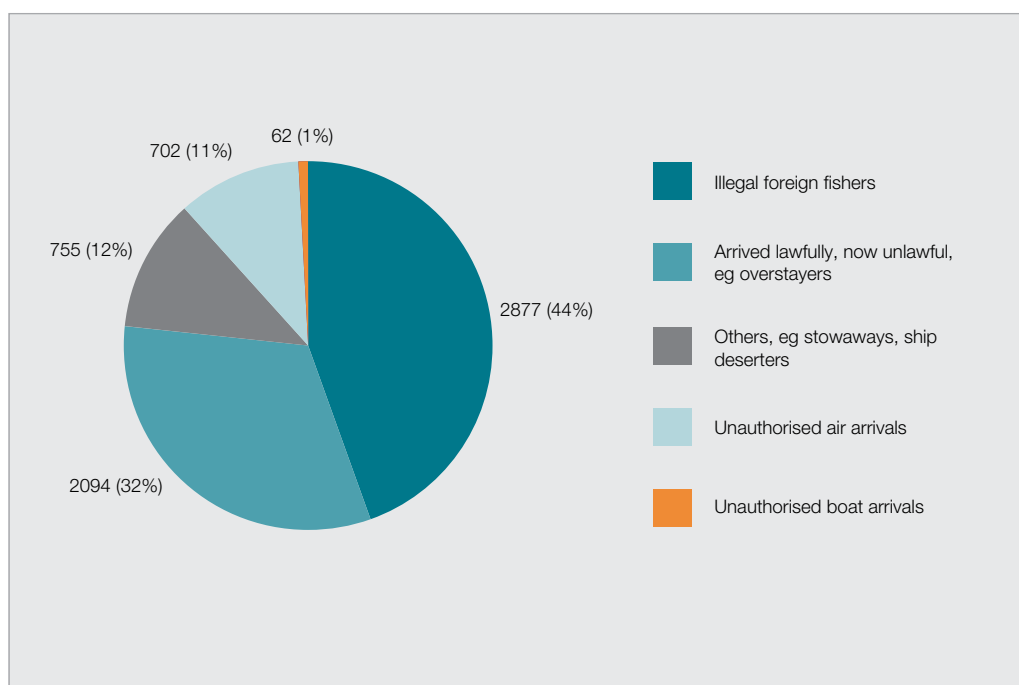
Group 2: people who arrive unlawfully

People in this group enter the migration zone (the states and territories of Australia) without a valid visa as one of the following:

- an unauthorised air or sea arrival
- an unauthorised boat arrival
- an illegal foreign fisher.

Figure 3.1 shows people entering immigration detention during the 2005–06 financial year, grouped according to how they arrived in Australia.

Figure 3.1 People entering immigration detention by arrival type: 1 July 2005 to 30 June 2006¹²

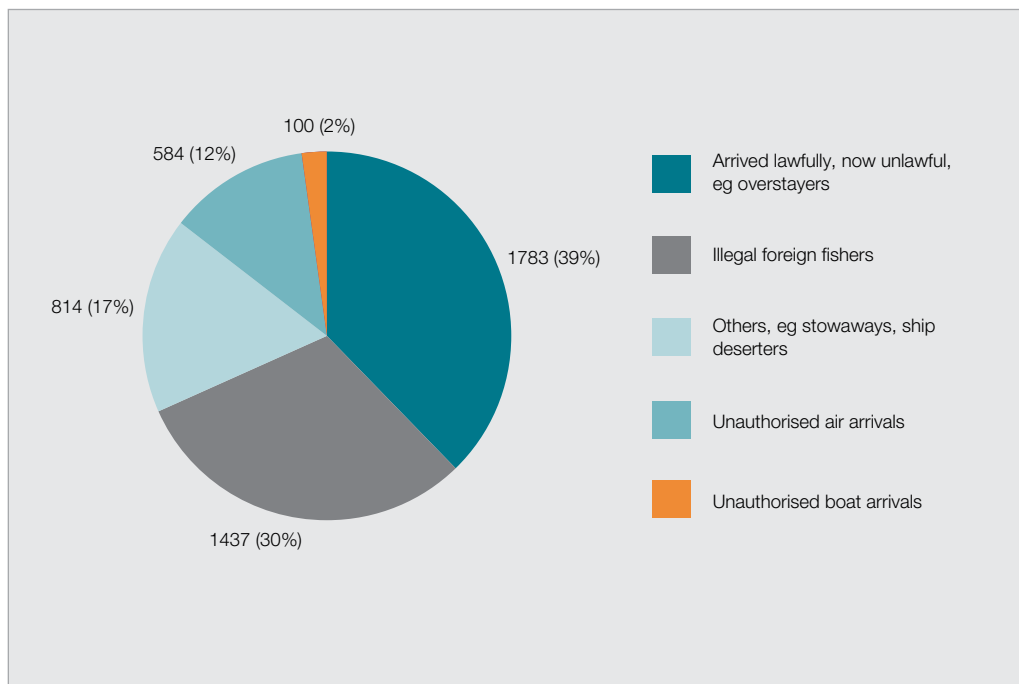


Because of the temporary nature of immigration detention, there is a big difference between the number of people who enter detention in a given year and the average number of people in detention on any given day. The average number of people in detention on any given day during the 2005–06 financial year was 826 people (an average of 245 illegal foreign fishers and 581 others).

¹² Note that 'offshore entry persons', who arrive at an excised offshore place and are taken to a declared third country to have any claims for protection assessed, are included in these statistics and in Figure 3.2 (see also Section 2.2 Offshore entry persons).

Figure 3.2 shows the same breakdown for the 2006–07 financial year.

Figure 3.2 People entering immigration detention by arrival type: 1 July 2006 to 30 June 2007

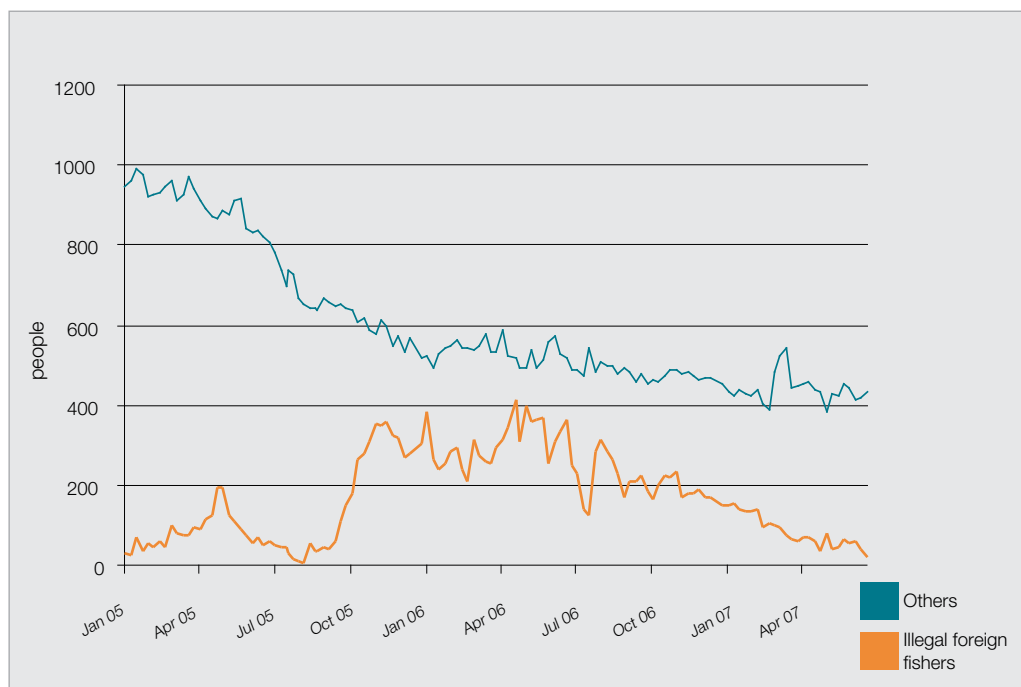


Numbers have continued to fall in the 2006–07 financial year, with the average number of people in detention on any given day standing at 595 people (an average of 137 illegal foreign fishers and 458 others).

The proportions of the various categories can vary markedly from month to month. However, as these graphs demonstrate, by far the largest numbers of people in immigration detention are those who arrived lawfully but have become unlawful because they have breached their visa conditions or overstayed their visas, and illegal foreign fishers. Unauthorised boat arrivals consistently represent the smallest segment taken into immigration detention and were 2% in the 2006–07 financial year, (increased from 1% in 2005–06).

Figure 3.3 shows a clear increase since January 2005 in the proportion of illegal foreign fishers in the detention caseload. As a consequence, the illegal foreign fishers issue has featured more prominently in government policy. It is unclear at this stage whether the decrease since October 2006 is a seasonal fluctuation or a long-term trend.

Figure 3.3 People in immigration detention from January 2005 to June 2007: illegal foreign fishers and others



The sustained long-term downward trend for people in detention other than illegal foreign fishers is clearly demonstrated.

3.2 Source countries

The composition of the immigration detention population is highly fluid due to international external factors that are outside Australia's control. These range from regional violence and conflict to changes in source countries for tourism and business travellers. A detailed analysis of trends is beyond the scope of this framework. However, the following figures show this fluidity and highlight the need for detention health services to adapt quickly to changing client demographics.

As Figure 3.4 shows, the two largest source countries in 2001 were Afghanistan and Iraq, reflecting regional conflicts at that time.

Figure 3.4 People taken into immigration detention: top ten source countries (2001)

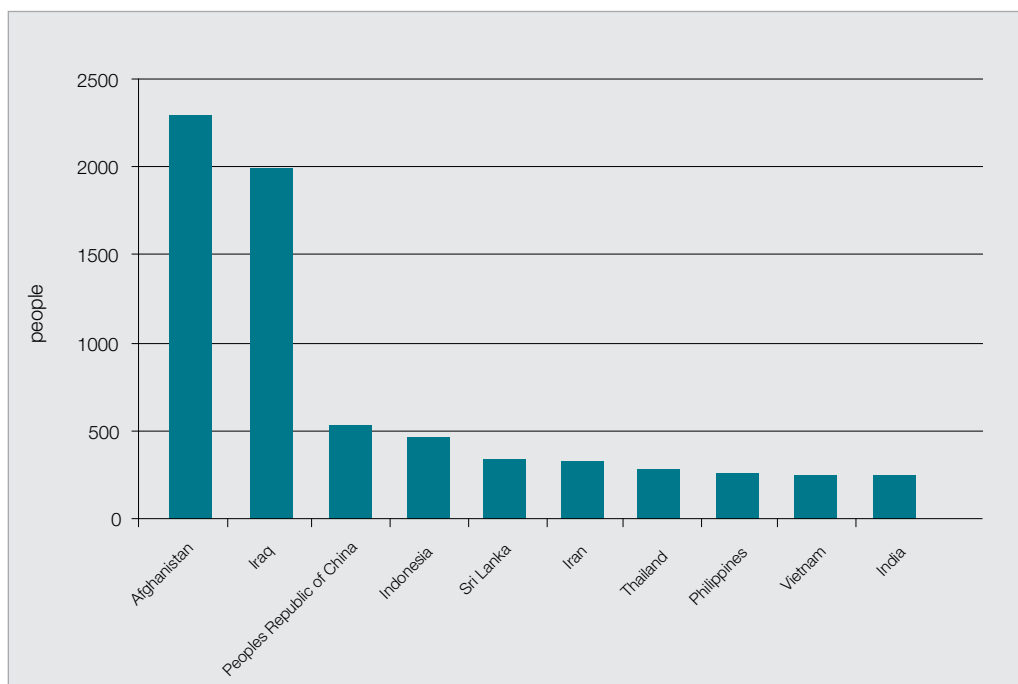
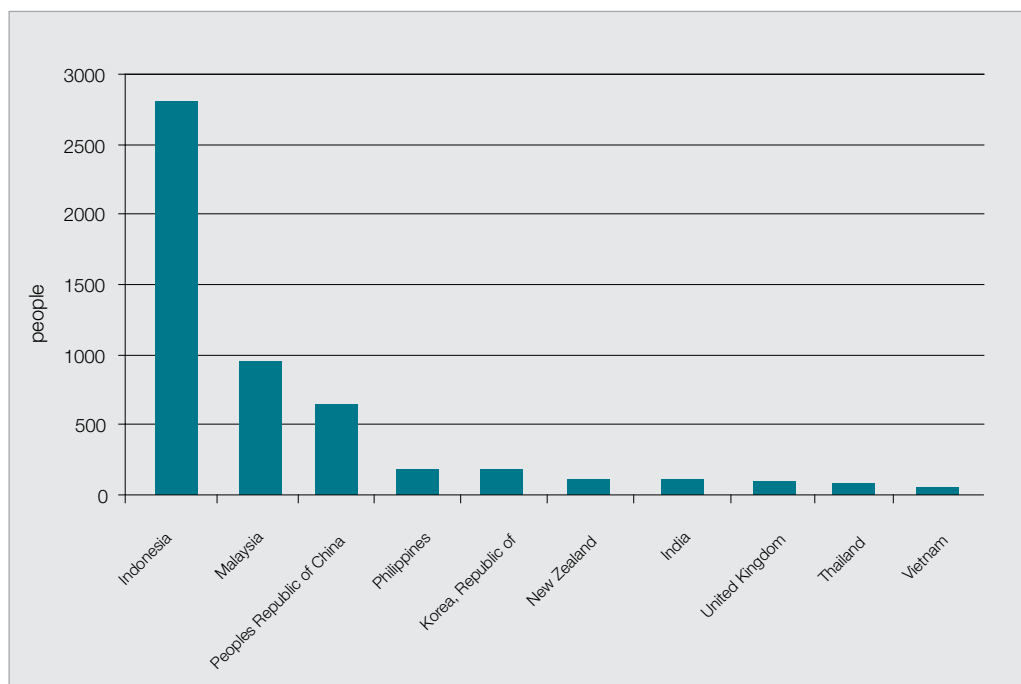


Figure 3.5 shows a different situation in 2006, with the largest group being Indonesian fishers.

Figure 3.5 People taken into immigration detention: top ten source countries (2006)

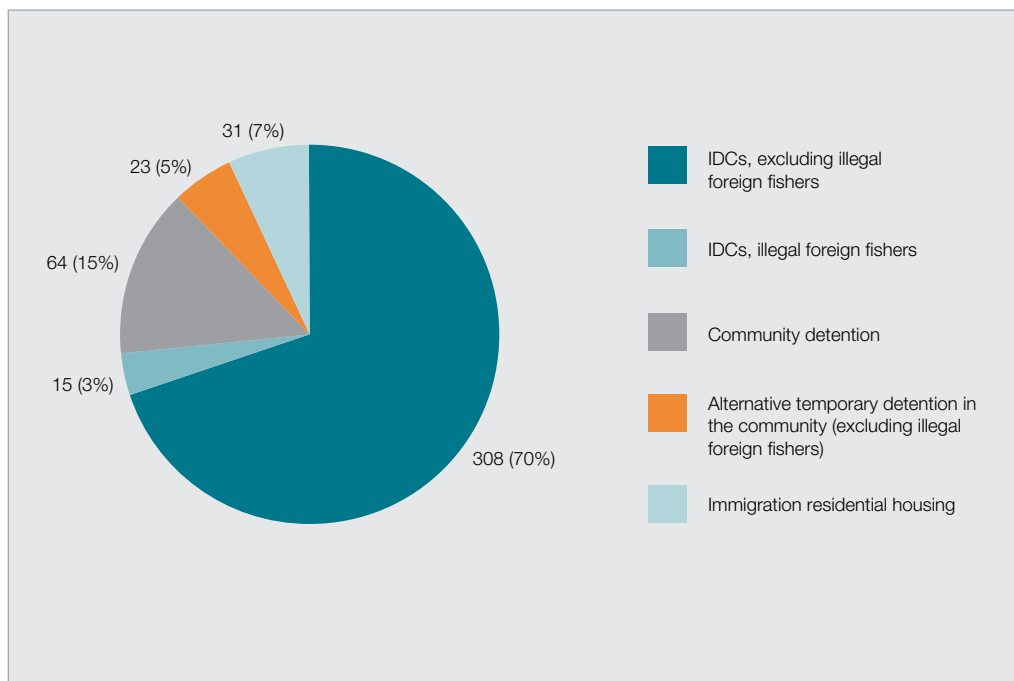


This picture could look different again for 2007 if the current decrease in numbers of Indonesian fishers continues.

3.3 Use of placement options

The type of accommodation into which people in detention are placed is clearly of great importance to their experience of wellbeing. Figure 3.6 shows the breakdown of the detention population by placement.

Figure 3.6 People in immigration detention by location at 30 June 2007



The percentage of people accommodated in alternative placements, such as immigration residential housing and immigration transit accommodation, will rise in the future as these accommodation options become operational in 2007 and 2008.

3.4 Detention duration

Equally important to people is the duration of their time in immigration detention. The length of time people are remaining in detention has changed. Figure 3.7 provides a five-year perspective on the number of people in detention for less than, and more than, nine months.

Figure 3.7 Number of people in immigration detention from July 2002 to June 2007

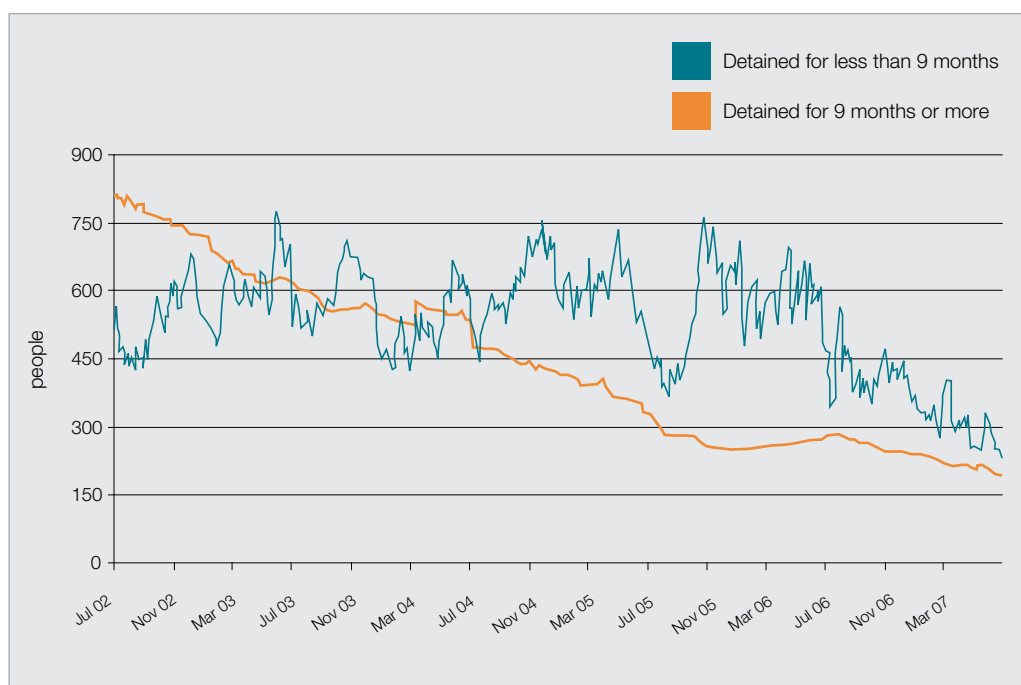


Figure 3.7 shows the detention population generally in decline over this period, with the number of people detained for more than nine months declining at a faster rate. The number of people detained for more than nine months has declined several fold in absolute terms and gone from being the majority in 2002 to a minority in 2007. However, they still make up a significant proportion of the detention population and the pipeline suggests that the numbers will remain significant for some time.¹³ People detained for longer periods may be exposed to greater health risks due to their length of detention and ongoing uncertainty over their immigration status. The detention health system must respond carefully to the needs of these people, and the Australian Government Department of Immigration and Citizenship (DIAC) continues to pursue options to speed up immigration detention processes, such as by introducing case management.

¹³ Advice from Mary Durkin, A/g Deputy Ombudsman, Commonwealth Ombudsman, 18 June 2007.

Note that Figure 3.7 shows the trend of the number of people in detention on each given day over a five-year period. While useful to analyse trends, the figure does not give an accurate picture of detention durations for all people passing through the detention system. Figures 3.8 and 3.9 provide a better indication of this.

Figure 3.8 shows a breakdown of the 2005–06 detention population by category (reason for being unlawful) and duration of stay. The graph clearly shows that the vast majority of people remain in immigration detention for less than three months. Of the 7375 people held in immigration detention in 2005–06, 85.9 per cent were held for less than three months — a slightly greater proportion for illegal foreign fishers (93.5 per cent) and slightly less for the remaining groups combined (80.9 per cent).

Figure 3.8 Duration of detention (2005–06 financial year): three-month comparison point

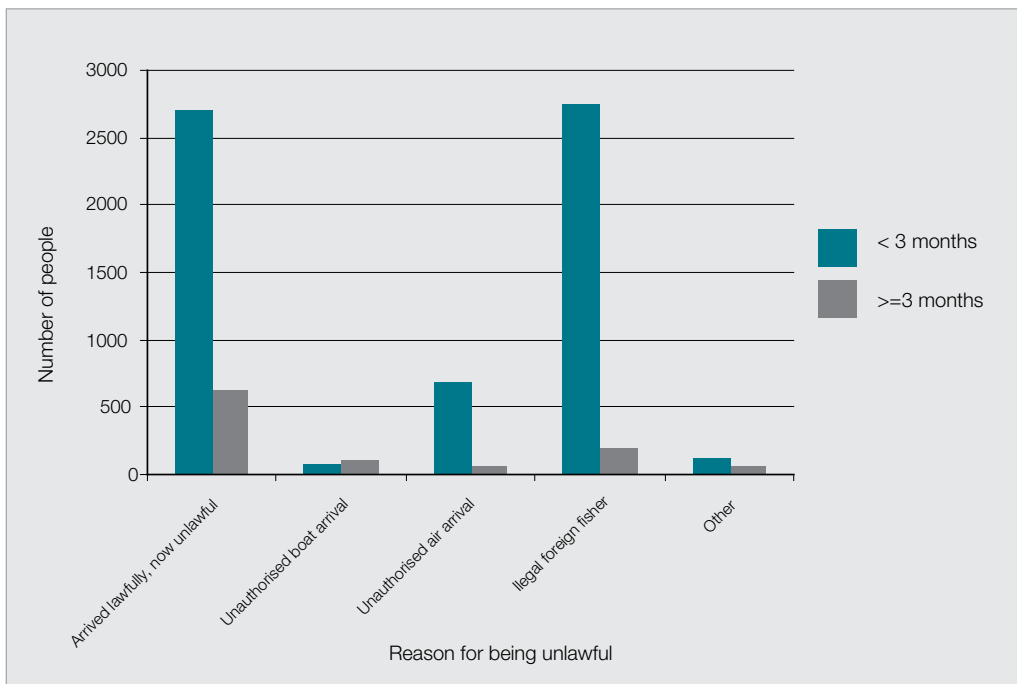
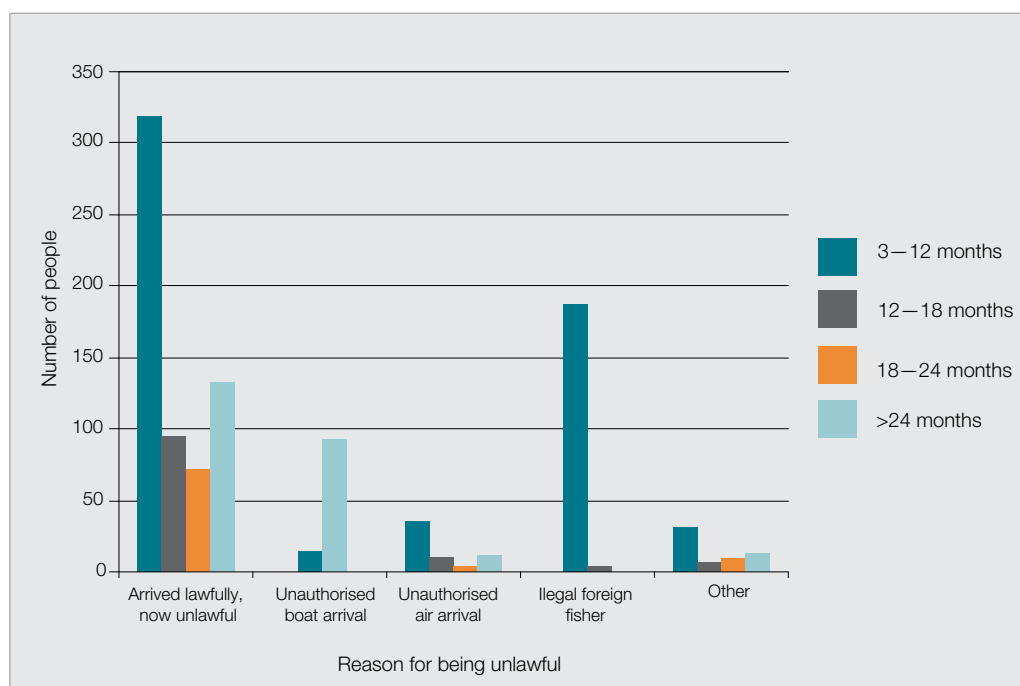


Figure 3.9 shows a more detailed breakdown of detention durations for the remaining 14.1 per cent of people held in detention for more than three months. Again, the data show that the numbers tail off noticeably after 12 months with one exception; unauthorised boat arrivals are a small proportion of the population but they have the greatest risk of extended periods of detention.

Figure 3.9 Duration of detention (2005–06 financial year): people detained longer than three months



4 Health in the detention environment

This chapter provides an overview of what is meant by health in the detention context and outlines the five core health principles that form the basis of the *Detention Health Framework*.

4.1 What 'health' means in the detention context

The Australian Government Department of Immigration and Citizenship (DIAC) is responsible for looking after the health and wellbeing of people in immigration detention. DIAC does this by focusing on wellness and by providing access to appropriate health care.

Health has been defined by the World Health Organization as a 'state of complete physical, mental and social wellbeing and not merely absence of disease or infirmity'.¹⁴ Contemporary approaches to health care reflect this by adopting a biopsychosocial model; that is, an approach to health care that acknowledges the biological, psychological and social aspects of illness and wellness. A key strength of the biopsychosocial model is that it emphasises the person's subjective experience as an essential contributor to accurate diagnosis, health outcomes and humane care.

The biopsychosocial model recognises that people require a range of factors to be in place to support wellbeing. A person's definition of wellbeing may change depending on their social and cultural differences. The following factors may also influence wellbeing:

- health
- personal relationships
- safety
- standard of living
- future security
- sense of community
- achievements in life
- spiritual beliefs
- recreational activities.

While immigration detention is administrative rather than corrective detention, it is an involuntary state and has the potential to undermine health and wellbeing. A goal of DIAC's service delivery model for immigration detention is '... to ensure that the only change to an individual's well-being as a result of being in detention is the restriction of freedom of movement'.¹⁵ While restriction of freedom of movement necessarily curtails some other freedoms, the intent of this goal is clear: to bring about the least restriction of freedom possible within the constraints of detention under the *Migration Act 1958*.

¹⁴ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization 2:100). www.who.int/about/definition/en/print.html

¹⁵ www.immi.gov.au/about/contracts-tenders/detention-services/_pdf/SDM.pdf

In addition to DIAC's responsibility to ensure that the impact of detention is reduced by providing a safe and secure environment, there also needs to be a focus on promoting good health and preventing illness in the detention context. Promotion and prevention measures are described in Section 6.2 (Spectrum of health care in immigration detention).

The placement model (Figure 2.1) aims to reduce the potential of the immigration detention environment to adversely affect the health of people in detention, thereby helping to ensure that the detention environment is in line with the broader, biopsychosocial definition of health. Notwithstanding this, people in detention may experience ill health, and the *Detention Health Framework* specifies how access will be provided for the full range of necessary health services, regardless of where people are located.

4.2 Five core health principles

There are five core principles that underpin detention health. These build upon the nine core operating principles for onshore detention described in Box 1.1.

4.2.1 Person-centred approach

In addressing health issues, DIAC's *Detention Health Framework* recognises that there is a range of influences, events and experiences that shape a person's health status. The framework also acknowledges that these experiences (as well as their cultural, sociopolitical and religious context) determine the way a person understands their own health experience. Managing the health and wellbeing needs of people in immigration detention requires a person-centred approach that recognises each person's unique health and wellbeing requirements. Health and wellbeing interventions are delivered in this context.

Also underpinning a person-centred approach is the fundamental right of every person in detention to be treated with dignity and respect. Human rights obligations for those involved in the provision of detention and health services are set out in a range of international instruments and domestic legislation. For health professionals, these obligations are augmented by a range of professional standards and codes, including the Royal Australian College of General Practitioners *Standards for Health Services in Australian Immigration Detention Centres*, which emphasises the importance of respectful and culturally appropriate care. DIAC's slogan, *People: Our Business*, was deliberately chosen following the Palmer and Comrie reports to emphasise that people are at the centre of the department's activities.

Given the cultural diversity among people in immigration detention, a person-centred approach requires the health care system, and the health professionals within it, to have a high degree of cultural competence by developing an understanding of who people are and what is important to them, and by tailoring health care accordingly. In all cases where language is a barrier to communication, appropriately qualified interpreting services must be used.

Finally, a person-centred approach demands a conscious focus by the health system and other detention services on health promotion and illness prevention. The health system and related services cannot prevent someone's detention but they can provide an environment in which a conscious and continuing effort is made to minimise health risk factors and maximise protective factors.

4.2.2 Appropriate health assessments

The nature and extent of biological, psychological and social health risk factors among people entering immigration detention varies greatly, and the health assessment approach must respond flexibly to this variation. Examples include torture and trauma, pre-existing illness and poor previous health care. In the past, health assessment processes for entry to, and exit from, immigration detention were largely the same regardless of where, or how, the person became an unlawful non-citizen, or the circumstances of immigration detention. An important goal of the *Detention Health Framework* is to provide an approach to physical and mental health assessment that successfully detects health problems but avoids subjecting people to unnecessary and potentially intrusive assessments.

To achieve positive health outcomes for people in the detention environment, the detention health service provider now uses a risk-based assessment approach. This approach relies on three things:

- providing a core set of assessments to all people entering detention
- matching additional assessments to risk factors that tend to cluster within groups
- augmenting these with other relevant assessments triggered by clinical enquiry.

Individuals and groups identified at higher risk for negative physical, social or mental outcomes receive targeted assessment and are offered interventions earlier in an effort to prevent such outcomes. Those not displaying these risks are spared unnecessary interventions. Well-targeted preventive interventions can result in significant improvements in health status and quality of life and can help reduce overall costs of care.

4.2.3 Shared responsibility

The principle of shared responsibility refers first to the relationship between a person in detention and their health care provider. In a secondary sense, it refers to the responsibility of all personnel working in the detention environment to be alert to, and act on, early signs that a person may be experiencing difficulties.

The fundamental principle of shared responsibility is that people who are competent to make individual choices about their own health care are encouraged to do so, and their choices are informed, respected and supported.

Where people are deemed not to be competent to make informed choices, DIAC will use independent representatives to work with people to ensure their interests are being served. In particular, the department will provide assertive identification, psychiatric assessment and care for people with serious mental illness.

It could be argued that the first obligation of clinicians in the immigration detention environment is to enable people to make informed choices about their own health care. In a post-Palmer culture characterised by a necessary concern for the wellbeing of people in detention, there is a risk that the health care system could become overly paternalistic such that choice is removed and individuals are 'cared for' regardless of their wishes. The aim of the *Detention Health Framework* is to outline a comprehensive system of health care that incorporates access to quality services and encourages choice and respect. Clinicians make health assessments and explain these to people in detention in a way that they can understand, and people are given an opportunity to act on advice by accessing available services. Excellence in communication, especially sensitive, cross-cultural communication, is clearly critical to this approach.

The extent to which this goal is achievable will vary greatly from case to case, and it must be recognised that some people are limited socially in their ability to engage in an equal partnership with health providers. A range of factors, including cultural differences, mental illness and past experiences may cause people to mistrust authority and prevent an effective health partnership. In some cases, this may mean that people in detention choose to adopt a more passive role in decision making within the health partnership. However, in all cases, it gives rise to a greater need for health service providers to build trust with people, to develop an understanding of who they are and what is important to them, and to encourage a more active role over time.

Shared responsibility also extends to the range of other DIAC and detention service provider staff working in detention centres. With support from their employers in the form of mental health awareness training and ongoing reinforcement in the workplace, these personnel have a responsibility to be informed about mental health issues — to put aside preconceptions, to avoid assumptions, to be alert to early signs that a person may be in psychological difficulty, and to inform a health service provider when they have concerns.

The responsibility for ensuring that people in detention achieve the appropriate health outcomes must be shared between the consumer, departmental and detention service provider staff, and those who provide health services. Such collective responsibility implies that all groups work in partnership, within privacy constraints, to share appropriate health related information and work cooperatively to make decisions about individual health care. In practice, striking the right balance between respecting privacy and communicating assertively to respond to emerging health risks can be a complex business, especially where mental illness is involved. This issue is explored in more detail in Section 8.5.1 (Privacy of personal health information — a difficult balance).

4.2.4 Effective governance

Governance within the detention context is supported organisationally by a well-defined structure of governance bodies. These bodies make decisions to define expectations, grant power and verify performance. There are many definitions of governance, reflecting the wide variety of contexts within which government operates. However, the following definition relating to the governance of nation states is useful in the detention context:

Good governance is epitomized by predictable, open and enlightened policy-making, a bureaucracy imbued with a professional ethos acting in furtherance of the public good, the rule of law, transparent processes, and a strong civil society participating in public affairs.¹⁶

Many elements of this definition match DIAC's three key strategic themes:

- an open and accountable organisation
- well-trained and supported staff
- fair and reasonable dealings with clients.

In the past, a detention services provider was responsible for providing all services to people in detention, under a contractual arrangement with the Australian Government (represented by DIAC). In September 2006, contracts for the provision of health and psychological services, and for security and enforcement services, were separated so that decisions about the health care of people in detention would be made by a clinically independent health service. Ensuring that people in detention are aware of this delineation between providers is important for building trust in the area of health care provision.

DIAC is further increasing its openness and accountability by working with external organisations, such as the Detention Health Advisory Group, to develop open and enlightened health policies for managing health care for people in immigration. The development and publication of this *Detention Health Framework* and the Royal Australian College of General Practitioners *Standards for Health Services in Australian Immigration Detention Centres* are examples of transparent processes that provide clear guidance to staff for improving the quality of health care provided to people in detention.

Section 8.2 (Effective governance) provides more information about the contractual arrangements defining responsibilities and performance measures for delivering health services in immigration detention. It also describes the governance bodies and processes that operate in the detention health environment.

¹⁶ World Bank (1994). *Governance: The World Bank's Experience*, World Bank, Washington.

4.2.5 Evidence-based decision making

Decision making at all levels of the detention health care system will be based on the best available evidence. This applies to individual clinical practice and to systemic issues, such as health promotion interventions and organisation of service delivery. Where there is uncertainty, DIAC and the Health Services Manager will seek to identify the most appropriate evidence-based approach through research or through expert consensus from external bodies, such as the Detention Health Advisory Group or the Royal Australian College of General Practitioners. In cases where there is no research or inadequate information in significant areas, DIAC will consider commissioning appropriate research.

5 Health risks and issues for immigration detention

This chapter outlines the key health risks and issues that shape the health care response in the immigration detention environment, and provides an overview of risk profiles within five broad groups.

Health risks and issues in the detention population fall into two categories. The first category consists of generic risks and issues that are associated with the restriction of freedom brought about by detention, and the cultural diversity of the detention population. It is important to note that generic health risks are not restricted to immigration detention centres; many health risks apply equally to the less restrictive placements, such as community detention, where people must still report regularly to the Australian Government Department of Immigration and Citizenship (DIAC). Regardless of placement, many people in detention experience uncertainty about immigration outcomes and, for those who have breached visa conditions, fear, stemming from the fact that they will most likely be removed from Australia.

The second category of health risks and issues are those that are specifically associated with the way people come into detention and their experience in their place of origin or on their journey to Australia.

5.1 Generic health risks and issues

5.1.1 Uncertainty about the future

Uncertainty about a fundamental aspect of the future — the country in which one will live — is an experience common to many people across the range of immigration detention placements and, indeed, to the far greater number of people living in the community on Enforcement Bridging visas. Coupled with other risk factors, this uncertainty can increase the likelihood that someone will experience a mental health problem. DIAC is investing heavily in case management and other initiatives to speed up immigration outcomes for people in detention, thereby decreasing the time spent living with this uncertainty. However, it is inevitable that some people will remain in detention for longer periods, awaiting the outcomes of lengthy merits and judicial review processes.

5.1.2 Delivery of health care in a controlled environment

An inherent challenge of delivering health care in immigration detention centres is the fact that they are controlled environments.

The first aspect of this risk relates to the difficulty of establishing trust with people who are involuntarily detained. Without clear and consistent messages to the contrary, the close working relationships between health care providers, departmental officers and detention service personnel could easily cause people in detention to mistakenly assume that health providers are part of the same organisation and are therefore unable to provide the level of confidentiality and independent decision making required to create trust. The importance of clearly explaining and constantly reinforcing the separation of health care and detention service providers, and the importance of confidentiality and privacy principles, is essential for minimising the loss of trust in medical staff.

A highly controlled environment, especially one in which rules are applied inflexibly, has the potential to create a confrontational atmosphere that breeds negativity and protest, escalating conflict and harm. Such an atmosphere can be seen as a health risk factor in itself. The detention reform process, particularly the service delivery model for immigration detention, directly addresses this issue by setting explicit objectives to create a supportive culture, provide appropriate amenities and promote a healthy environment. All personnel working in the detention environment must help to ensure that the controlled nature of immigration detention centres does not become oppressive. Equally important are initiatives to reinforce protective factors that promote community engagement, such as excursions and activities.

Finally, a high-quality health service does not of itself guarantee good health outcomes.

Emphasis must be given to providing a humane and well-managed detention environment that positively influences the range of health determinants that lie outside the health system.

This principle is expressed in the Royal Australian College of General Practitioners *Standards for Health Services in Australian Immigration Detention Centres*:

These Standards do not, and cannot, address all the impacts on the health and wellbeing of people detained in Australian immigration detention centres. A range of issues impacts on health and wellbeing (such as housing, nutrition, physical activity) that reinforce the effects of high quality and safe health care provided by the health service. These issues are beyond the scope of these Standards and will need to be addressed by the Australian Government and the companies contracted to manage the day to day operations of immigration detention centres.¹⁷

¹⁷ Royal Australian College of General Practitioners (2007). *Standards for Health Services in Australian Immigration Detention Centres*, Royal Australian College of General Practitioners, Melbourne, 5. www.racgp.org.au/standards/detention

5.1.3 Delivery of health care to a culturally diverse population

Most people in detention come from culturally and linguistically diverse backgrounds. Many have social, religious and cultural standards and expectations that require careful consideration when providing health services. The dignified and empathetic manner in which health services are to be provided requires that these special needs be respected and taken into consideration by health service providers.

The inability to adequately communicate one's needs can be stressful in any environment. Using qualified interpreters to support people in detention is a fundamental right in this context — although it is only a starting point. Cultural competency is an emerging concept that is gradually replacing traditional concepts of cultural awareness and cultural sensitivity. A recent National Health and Medical Research Council publication on cultural competency provides the following definition:

Cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations (Cross et al 1989 cited in Eisenbruch 2004a). Cultural competence is much more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services.

To become more culturally competent, a system needs to:

- value diversity;*
- have the capacity for cultural self-assessment;*
- be conscious of the dynamics that occur when cultures interact;*
- institutionalise cultural knowledge; and*
- adapt service delivery so that it reflects an understanding of the diversity between and within cultures.¹⁸*

To succeed in a health setting, understanding cultural difference must go beyond cultural stereotypes and recognise that there are wide variations within many racial and cultural groups, and that some individuals may not identify with the dominant culture of their country of origin. Fundamental to cultural competence is a willingness to investigate with the person the issues that are important to them and to provide individualised health care that addresses those issues.

Diagnostic difficulties may also arise for health care providers as a result of the mix of cultural and linguistic groups within a detention environment. An area of particular concern is in the diagnosis of mental health problems and subsequent assessment of any self harm risk, the expression of which can vary markedly between cultures.

¹⁸ National Health and Medical Research Council (2006). *Cultural Competency in Health: A Guide for Policy, Partnerships and Participation*, National Health and Medical Research Council, Canberra.
www.nhmrc.gov.au/publications/synopses/_files/hp19.pdf

5.2 Specific health risks and issues

5.2.1 Communicable diseases

Access to health care, education and initiatives that reduce harm is important for managing communicable diseases in detention settings. Experience indicates that the prevalence of blood-borne viruses, sexually transmissible infections and other communicable diseases is higher in some sections of the detained population than in the general population due to the poor conditions in the countries from which clients have arrived.

Screening for communicable diseases will involve a two-tiered risk assessment framework based on:

- country(ies) of former residence, for example screening for yellow fever would be indicated for people from Africa but not from Singapore
- personal risk factors as assessed and determined by health care practitioners, for example patterns of illicit drug use.

5.2.2 Mental illness

Since its inception in February 2001, the Immigration Detention Advisory Group has highlighted the importance of mental health issues in immigration detention. The Palmer and Comrie reports, and a number of subsequent ombudsman's reports, have explicitly warned DIAC about the risk of failing to identify people with mental health problems who may incorrectly be placed in immigration detention, despite being lawfully in Australia. In addition, the prevalence of risk factors for mental illness among people who enter immigration detention exceeds those in the general population.

The Commonwealth Ombudsman (Immigration Ombudsman) has highlighted 11 specific cases where mental illness or incapacity played a significant role in the wrongful detention of a person lawfully in Australia.¹⁹ Several of these highlighted a lack of assertive psychiatric assessment and care for people in the detention population with serious mental illness. This framework places a high priority on providing this assessment and care.

Factors associated with detention may adversely affect a person's mental health and wellbeing. These factors include isolation, uncertainty, separation from loved ones and friends, inability to make decisions and a lack of access to normal ways of coping.

Mental illness may be episodic or chronic. As thinking, perceptions, feelings and behaviours may change over time and in response to circumstances, people in immigration detention may require access to assessment and treatment services a number of times while in detention. Mental health assessment and treatment services should be flexible and able to respond to changes in an individual's mental state.

¹⁹ *Lessons for Public Administration: Ombudsman Investigation of Referred Immigration Cases, August 2007*, report 11|2007 by the Commonwealth Ombudsman, Prof John McMillan, under the *Ombudsman Act 1976*.
[www.ombudsman.gov.au/commonwealth/publish.nsf/AttachmentsByTitle/reports_2007_11/\\$FILE/report_2007_11.pdf](http://www.ombudsman.gov.au/commonwealth/publish.nsf/AttachmentsByTitle/reports_2007_11/$FILE/report_2007_11.pdf)

As in the wider community, there is potential for people in immigration detention with mental illness to encounter discrimination and stigma, which may prevent recovery. Discrimination and stigma must be addressed at a system level through initiatives such as mental health awareness training. Access to appropriate cultural support, including access to interpreters and advocates, can also act as a protective factor to help prevent or reduce the distress resulting from mental illness.

Supporting people with mental illness who are at risk of self harm is the joint responsibility of DIAC and mental health and other health care practitioners. Security services and health providers should work in partnership to identify similarities of purpose, develop protocols and identify roles and responsibilities for preventing suicide and self harm. Collaboration, open communication and appropriate exchange of information are essential for the appropriate management of people with mental illness in detention.

5.2.3 Torture and trauma

Trauma associated with previous torture, and the increased prevalence of mental illness among torture survivors, is an issue that deserves a special focus by health care in the immigration detention environment.

Exposure to a traumatic event is a common experience. Large community surveys in Australia and overseas reveal that 50–65 per cent of people report at least one traumatic event in their lives. Most people will have some kind of psychological reaction to trauma — feelings of fear, sadness, guilt and anger are common. However, most people recover over time with only a small proportion developing acute stress disorder or post-traumatic stress disorder (PTSD). It is estimated that more than a quarter of a million Australians experience PTSD in any one year, and that around 5 per cent of people have had PTSD at some point in their lives.²⁰

People from certain geopolitical situations are much more likely than others to have experienced torture. In contrast to the estimated 5 per cent of Australians who develop PTSD following trauma, studies on overseas populations exposed to high rates of torture have found rates of PTSD in excess of 30 per cent, often accompanied by elevated levels of anxiety, social dysfunction and severe depression. DIAC is acutely conscious of the need to avoid the immigration detention environment extending damage caused by pre-existing torture.

Identifying people who have experienced torture and trauma is complex and not all have obvious physical or psychological signs. People with acute stress disorder and PTSD will not necessarily mention the fact that they have had a traumatic experience when they first see a doctor or another health professional. They may present with any of a range of problems, including anger, relationship problems, poor sleep or physical health complaints such as fatigue, headaches or gastrointestinal problems. The distress and stigma associated with mental health problems or traumatic events may prevent some people from talking about their experience.²¹

²⁰ Australian Centre for Posttraumatic Mental Health (2007). *Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder: Practitioner Guide*, Australian Centre for Posttraumatic Mental Health, Melbourne. www.nhmrc.gov.au/publications/synopses/mh13syn.htm

²¹ *Ibid*

In response to a recommendation by the Immigration Detention Advisory Group, DIAC is developing new guidelines to ensure that people who have experienced previous torture and/or trauma are identified and that their detention placement does not exacerbate their condition. The identification and appropriate treatment of survivors of torture and trauma is a high priority and DIAC is currently working with the Detention Health Advisory Group to develop a best-practice approach.

5.2.4 Poor previous health care

Excluding illegal foreign fishers, the vast majority of people entering immigration detention have lived in the Australian community and the risk of unidentified communicable diseases is low. However, people will reflect the general health indicators of the circumstances of their residence in Australia. Those who have come from Australian prisons, for example, may have alcohol and other drug problems that have not been adequately addressed.

Illegal foreign fishers and people recently arrived from certain countries with poor or non-existent health care may bring with them a range of pre-existing health problems. Examples include poor dental health, lack of immunisation, untreated parasites and bacterial infections, poor diagnosis and treatment of tuberculosis, sexually transmitted infections and a host of other health conditions.

Given that many people in immigration detention are ultimately removed from Australia, the degree to which detention health attempts to address poor previous health care is a highly complex issue. Aside from cost considerations, there is potential to cause harm at a population level. For example, if pharmacological treatment for tuberculosis is started and the person is returned to their home country before treatment is completed, there is a risk that the mycobacteria infection in the inadequately treated patient could become resistant, potentially leading to multiresistant strains of tuberculosis in the population.

DIAC's current approach is to maintain optimal health for people while in immigration detention. The emphasis is on providing a good standard of care that addresses acute presentations and public health risk, and prevents further illness. Where there are indications that a person is likely to remain in Australia following detention, or where risk assessment warrants preventative action, DIAC will provide standard health processes, such as immunisation.

DIAC recognises that this is a highly complex area and is seeking advice from the Detention Health Advisory Group to develop an evidence-based position on this issue.

5.3 Risk profiles for groups within the detention population

Most people who enter immigration detention fall into one of five broad groups and people within these groups tend to have common health issues. Tailoring health assessment and response to identified risks helps to avoid people being put through unnecessary assessments, while recognising that clinicians must remain vigilant for situations where a person may require assessment for health conditions not typical for a particular group. A project currently underway to collect, analyse and report on detention health data will help to ensure that these health risks are based on evidence and are refined over time. Until this data becomes available, judgments about the types of assessments relevant to each group are based on the best available evidence, including clinical experience.

The following sections outline the potential health problems for the different groups of people who enter Australia.

5.3.1 Group 1 – illegal foreign fishers

This group of people has a high risk of public health issues but requires less intensive care due to the shortness of their stay and their age and fitness level. With the exception of ships' captains and others who may be subject to legal proceedings in Australia, the brevity of detention for most fishers means that psychosocial risks are minimal and health care tends to focus on physical health. To protect the Australian community from communicable diseases such as tuberculosis, blood screening is a high priority for this group and ensures that health conditions are identified and treated appropriately. Health advice is given to provide a basis for ongoing health care following removal from Australia.

5.3.2 Group 2 – unauthorised boat arrivals

Unauthorised boat arrivals are a more diverse group than illegal foreign fishers and may have conditions that need specific health responses. These include:

- families with young children, who will need immunisation reviews and updates
- diverse cultural backgrounds, giving rise to a need for culturally competent health services (for example, the use of female doctors to examine female clients)
- people who may be seeking asylum from countries or geopolitical situations where torture and trauma is common, or where trauma or extreme hardship is experienced on the way to Australia, with a resultant need for high levels of initial psychological and physical health assessment and ongoing psychological assessment
- potentially increased prevalence of communicable diseases, giving rise to a need for blood screening similar to that provided for illegal foreign fishers.

5.3.3 Group 3 — people who have breached visa conditions

Most people in this group have undergone some level of immigration clearance before entering Australia and have made a declaration about their health when applying for a visa. This group can be divided into long or short term in the community. The level of health risk is likely to be lower than for those in Groups 1 and 2 and a full physical health assessment, including public health screening, may not be required or cost-effective for this group. However, the mental illness presentation in this group may be higher than the general population.

5.3.4 Group 4 — section 501 visa cancellations and criminal deportees

The minister can cancel a visa under section 501 of the *Migration Act 1958* if a person does not satisfy the character test, usually as a result of a serious criminal conviction. This group is a subset of Group 3 and consists of people who, because of serious criminal convictions, are transferred from a correctional facility to a detention centre. People in this group may have high levels of morbidity due to psychological and substance use disorders and may require ongoing care while in immigration detention. Immigration detention can extend a person's period of incarceration and the indefinite nature of immigration detention (after they have served a finite prison term) may expose them to greater risks of mental disorder. Ex-prisoners may have problems with anger and depression, personality disorders, and a history of childhood abuse and neglect — making their psychological care more complex and demanding. Their behaviour may also impact adversely on others in the detention environment.

5.3.5 Group 5 — unauthorised air and sea arrivals

This group includes stowaways, ship deserters and air arrivals travelling on false documents. A detailed health assessment may not always be required or cost-effective in view of the quick turnaround by many people in this group. However, a brief screening assessment is always conducted to determine whether a more detailed health assessment is warranted. Generally, this group may require an assessment of their fitness to travel. Stowaways or ship deserters may require a higher level of health care depending on their background and the circumstances of their arrival in Australia.

6 Models of health care

This chapter outlines the models of health care in the immigration detention environment — the spectrum of health care services people can access and the structure of health service delivery.

6.1 Overview of health care models

The overarching philosophy of detention health care is to ensure that people in detention have access to clinically recommended, quality health care, at a standard generally comparable to the health care available to the Australian community, taking into account the diverse and potentially complex health care needs of people in detention. The principle of comparability with the Australian community means that, for similar health problems, the health care provided for people in immigration detention should be the same as health care for anyone in Australia. For people in detention who are placed in the community, health care services are provided exclusively by community-based health providers.

When compared with mainstream health care, health care provided to people in detention differs in some ways as a result of the responsibility that the Australian Government Department of Immigration and Citizenship (DIAC) owes people in view of their involuntary status. For example, for people in detention (compared with mainstream health care):

- early intervention is more assertively pursued in certain areas, such as screening and assessment conducted on entry to, and exit from, immigration detention
- the Health Services Manager, in conjunction with DIAC and the detention services provider, has a responsibility to provide and promote activities to increase wellbeing that would normally be left to individuals to organise, such as opportunities for recreation, outings and engagement in community activities.

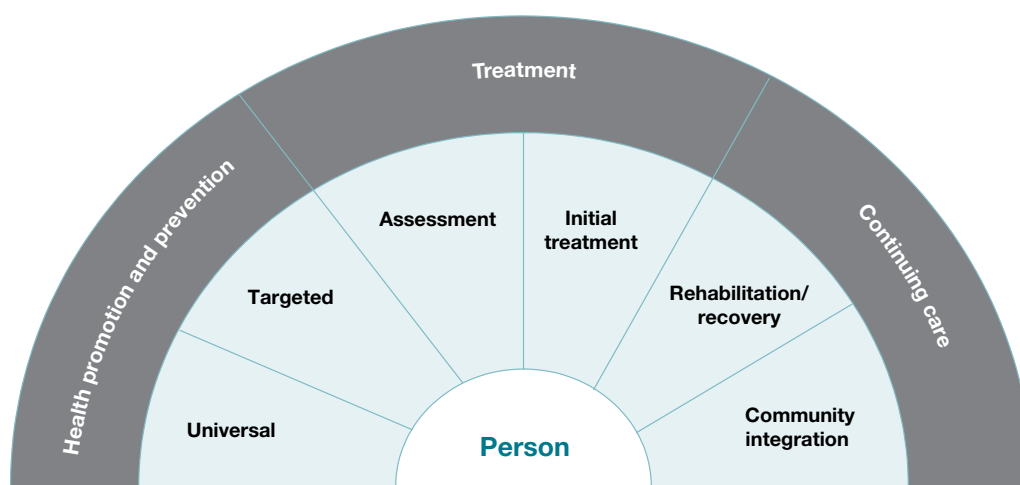
The *Detention Health Framework* describes a contemporary spectrum of health care consistent with what is expected within the general Australian community. It provides a balance across the whole spectrum of health services, from health promotion and prevention, standard treatment (with an emphasis on early intervention) and continuing health care. It makes use of inhouse primary care services and community-based primary, secondary and tertiary services, as clinically indicated, to ensure that no person in immigration detention is denied access to necessary health care. The framework provides continuity of care over time, from initial assessment through to discharge planning facilitating integration back into the community. It also encompasses aspects of health promotion and prevention specifically relevant to the immigration detention context.

6.2 Spectrum of health care in immigration detention

The spectrum of health care illustrated in Figure 6.1 depicts health care needs based on a graded series of responses required to prevent or treat the various stages of illness and recovery rather than a system perspective based on who provides health care services. It provides an expansive view of health care interventions in keeping with biopsychosocial model of health care. For example, health promotion and prevention includes initiatives such as the client placement model and the creation of healthy detention environments through activities organised by the detention service provider or non-government organisations.

Figure 6.1 does not explicitly show the wide variety of inhouse, public and private health care providers who provide a comprehensive spectrum of health care. These providers are discussed briefly below and in Section 6.3 (Health service delivery structure).

Figure 6.1 Spectrum of health care in immigration detention²²



Boxes 6.1–6.3 outline examples of wellbeing and health initiatives under each element of the spectrum shown in Figure 6.1. It is important to note that the detention health system adopts a choice-based approach. Unless there is evidence of public health risk, or a person is not competent to make informed choices about their health, people in detention are free to choose whether or not to use the health care provided.

6.2.1 Health promotion and prevention

The health promotion and prevention segments of the health care spectrum seek to improve the wellbeing of people in immigration detention and to prevent the onset of illness or the progression of illness past initial symptoms. Interventions can be universal or targeted as described in Box 6.1, below.

²² This model has been adapted from Mrazek and Haggerty (1994), *Reducing the Risks for Mental Disorders: Frontiers for Preventive Intervention Research*, National Academy Press, Washington. In the current context, the model encompasses biological, psychological and social aspects of health care.

Box 6.1 Health promotion and prevention for people in immigration detention

Universal health promotion

Universal health promotion and prevention initiatives are aimed at reducing generic risk factors and increasing generic protective factors for all people in detention. They include:

- access to recreational facilities and meaningful activities including, if desired, opportunities for work
- access to educational facilities
- opportunities to build community and increase social interaction within facilities
- engagement with non-government organisations and community groups
- general health awareness and education programmes that are culturally appropriate, including peer education programmes
- a safe and stable detention environment, free from bullying and environmental risks and hazards
- a culture that encourages individuals to take increased control over the determinants of health and thereby improve their own health
- provision and promotion of information for people in detention about the health services available and how they can access them
- processes for systematically identifying risk factors and for treating or removing those factors.

Targeted health promotion

Targeted health promotion and prevention initiatives are aimed at sub-groups within the detention environment who are at higher risk of developing health problems or who show early signs of health problems. They include:

- appropriate client placement to ensure that people with serious or complex health problems, or other risk factors, are not adversely affected by the detention environment
- targeted prevention and early interventions for those at risk or showing early signs of health conditions that may require ongoing care, for example diabetes and blood-borne viruses
- regular review by a multidisciplinary team of health professionals for people identified as having special needs, with a view to preventing complications and strengthening protective factors.

6.2.2 Treatment

The treatment segments of the health care spectrum cover the full range of health screens and assessments and the initial responses to identified health care needs, as shown in Box 6.2.

Box 6.2 Treatment for people in immigration detention

Assessment

Assessment refers to the range of formal and informal ways in which health issues are identified for people in detention, with an emphasis on early identification of health risks to support early intervention. These include:

- interviews to elicit personal and medical history
- physical examinations, ranging from basic checks conducted by a registered nurse or general practitioner to specialist screening for communicable diseases and blood-borne viruses
- formal mental health screening instruments and protocols, including screening for torture and trauma
- regular mental health rescreening for people detained for longer periods.

Most assessment activities occur as part of formal processes during entry to, or exit from, immigration detention, or as part of scheduled mental health rescreening for those who remain in an immigration detention centre for longer than three months. A range of other assessment activities may be triggered through self-referral, referral by friends, family, advocates, legal representatives or others in detention, or referral by departmental or security personnel.

Initial treatment

Initial treatment in this context refers to any treatment that is required to address a health problem identified through an assessment process. The bulk of initial treatment interventions will be similar to those that would routinely be provided through any general practice. However, initial does not imply 'basic' — it can also include the full range of allied health services available to the community, including dental, psychology and physiotherapy. Where clinically indicated, initial treatment can also include psychiatry, advanced diagnostic services, acute hospital admission and specialist consultations. Culturally appropriate interventions such as traditional Chinese medicine are also considered on a case-by-case basis.

Initial treatment focuses on early intervention and proactive case management to identify needs for continuing care and prevent progression to further health problems.

6.2.3 Continuing care

The continuing care segments of the health care spectrum cover ongoing health care with a focus on rehabilitation and recovery, and community integration. This is outlined in Box 6.3.

Box 6.3 Continuing care for people in immigration detention

Rehabilitation and recovery

Rehabilitation and recovery may involve any of the interventions described under the initial treatment segment to facilitate integrated and ongoing care for those whose health issues continue to recur. It focuses on the prevention of complications and a return to optimum health.

Mental health care for people in immigration detention has a focus on recovery, while acknowledging that some of the largest barriers to recovery are beyond the control of the consumer or the health service; for example, uncertainty about immigration outcome. Proactive case management aims to specifically address the many barriers to recovery. For example, client placement may be reconsidered to provide an environment most conducive to recovery. For people needing acute hospital admission for psychiatric problems, DIAC seeks to provide psychosocial support services through a non-government organisation to support recovery in the community.

Community integration

In many cases, maintaining an optimal level of health and promotion of recovery depends on a person's ability to interact socially with others in detention or in the general community. A person who is recovering from a serious health problem, particularly a mental health problem, may need greater support and contact with community groups, advocates and non-government organisations should be encouraged.

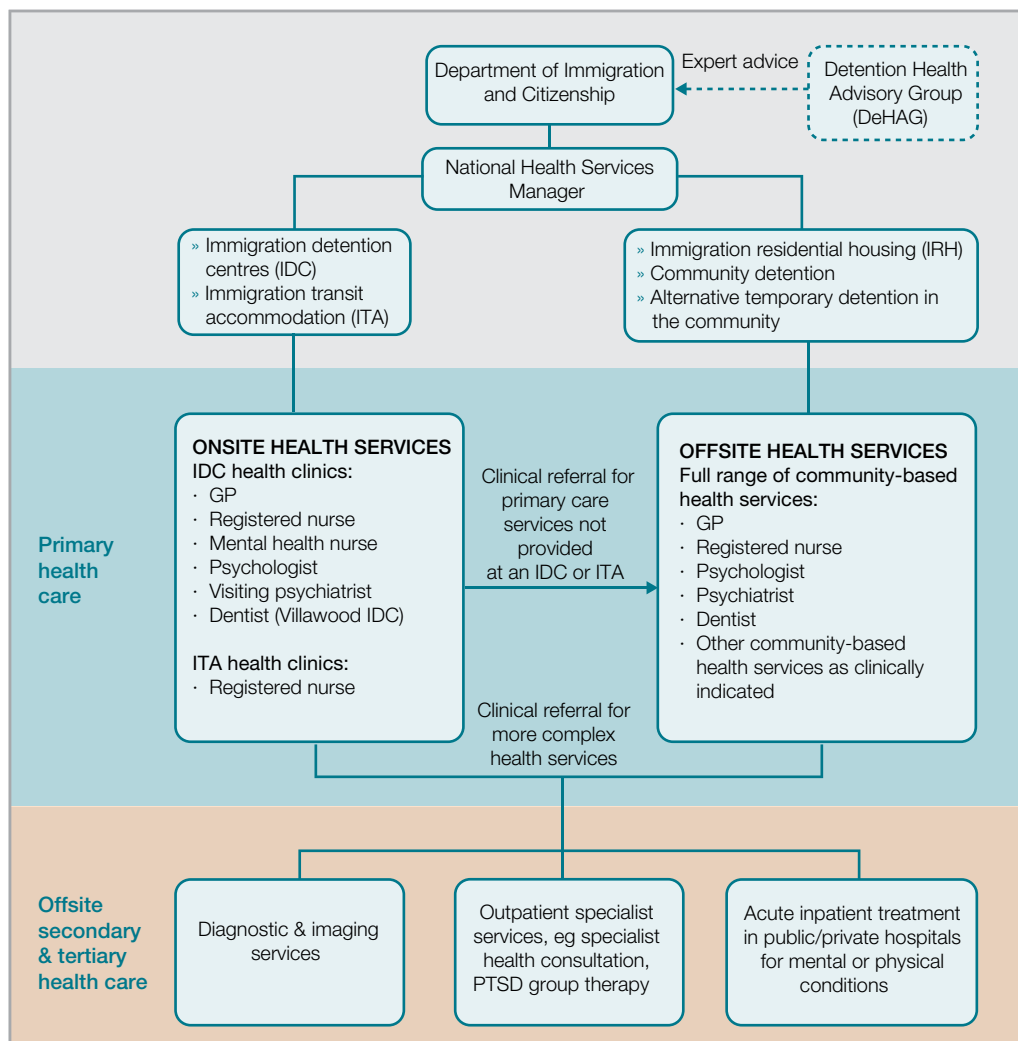
Community integration also refers to clinical linkages made through the health discharge process for people who require ongoing care. When appropriate, these referrals can be made to health providers based in the community or, where removal is pending, overseas.

6.3 Health service delivery structure

Health services for people in immigration detention will be managed by the national Health Services Manager responsible for managing and organising a range of health care services delivered by a multidisciplinary team of health care providers. The Health Services Manager may directly provide health care services, or broker these services through a network of external health care providers.

Figure 6.2 illustrates the contractual structure through which health services for people in immigration detention are delivered or brokered by a national health service manager on behalf of DIAC, and the network of primary, secondary and tertiary health providers, both inhouse and community-based, that is used to deliver the range of services described above in Section 6.2 (Spectrum of health care in immigration detention).

Figure 6.2 Detention health service delivery structure



6.3.1 Primary health care

Primary health is often described as the first level of health care that is directly accessible by individuals and communities. In the detention context, primary health care includes early intervention, routine health care (including dental health), chronic disease management and counselling. As shown in Figure 6.2, primary health care services are delivered by a range of providers depending on client placement.

Within immigration detention centres, most primary health care services are provided onsite by inhouse or visiting health care professionals. These are based on a clinic model where people in detention make appointments as they would if they were residing in the Australian community. For less frequently used services, onsite resources are supplemented by community-based health care providers.

In immigration transit accommodation, initial health assessments, most ongoing primary health care and health discharge assessments are provided onsite by registered nurses. For non-routine health services, arrangements will be made for people accommodated in immigration transit accommodation to attend offsite health providers.

For people in the range of other alternative detention placements, primary health care is provided solely by community-based health care providers coordinated by the Health Services Manager. DIAC's policy is that people in the range of alternative and community detention placements should not be required to go to an immigration detention centre to receive health care.

6.3.2 Secondary and tertiary health care

Secondary health care refers to diagnostic and treatment services for clients with conditions that require more complex and specialised skills and facilities, usually following referral from a primary care setting. In the detention environment, secondary health care services are provided by state or territory public health services and specialist outpatient appointments.

Tertiary health care services provide a greater level of specialist care that requires advanced forms of health intervention. Tertiary health care services are generally provided by state or territory and private hospitals.

The Palmer Report identified a need for greater clarity about the clinical pathways to hospital services for people in immigration detention. DIAC has formal memorandums of understanding with both the South Australian Department of Health and the Northern Territory Department of Health and Community Services for providing secondary and tertiary health services for people in immigration detention within their respective jurisdictions. Negotiations for similar agreements are underway with all other state and territory health departments and a number of private hospitals and providers.

A more detailed summary of health care arrangements by immigration placement is provided in Appendix A (Summary of health care arrangements by immigration placement).

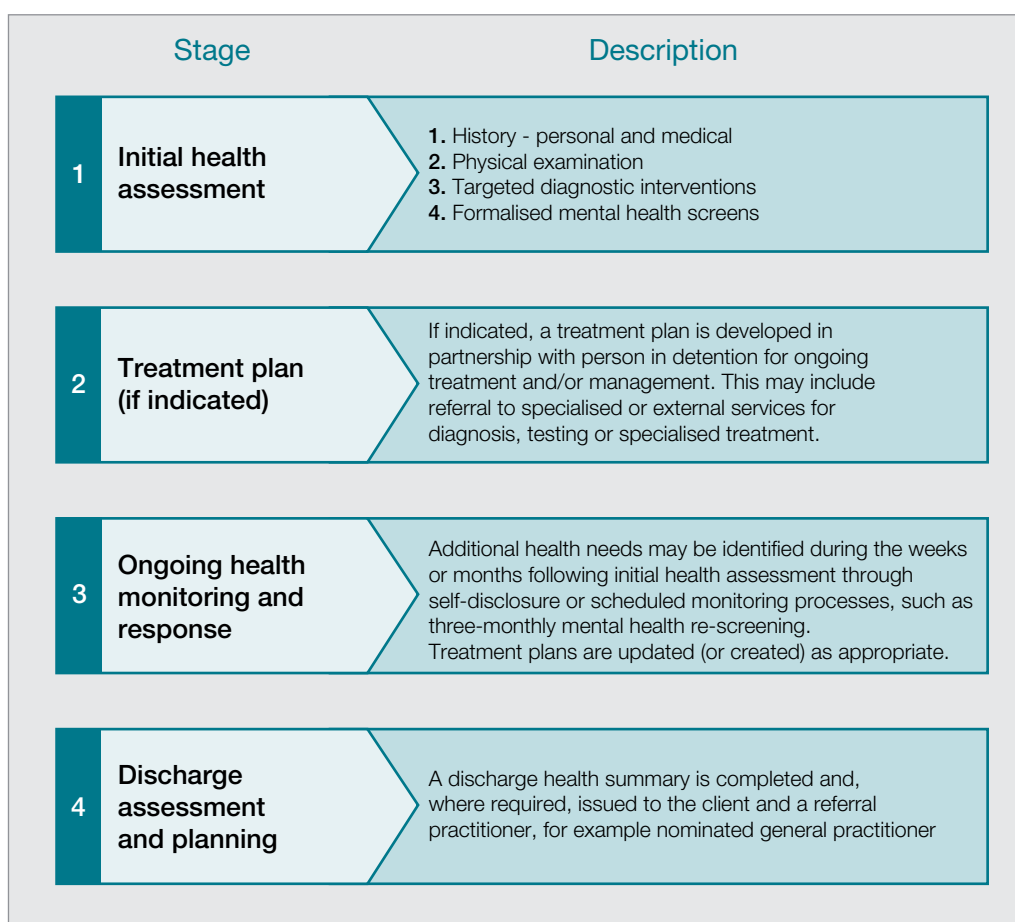
7 Health care processes in the detention environment

This chapter provides an overview of the health care process in immigration detention, from initial health assessment to discharge.

7.1 Overview of health care process

Figure 7.1 provides a high-level overview of the health care process for people in detention, from the initial contact with the detention health system to discharge. The four stages of the health care process are described in more detail in Sections 7.2–7.5.

Figure 7.1 Overview of the health care process



7.2 Initial health assessment

An initial health assessment will be done for every person in immigration detention (who consents) to identify conditions that will require attention while the person is accommodated in detention. Initial health assessment is arguably the most critical stage in the health care process and is based on the principles of tailoring assessments to health risk factors and intervening early to address existing or potential health problems.

The following process description reflects current protocols. These will change based on emerging evidence and continuous improvement.

All stages of the following process are conducted with informed consent. Informed consent must be supported by appropriately tailored and sufficiently detailed information about health care options and risks, and, where necessary, access to interpreters.

The four components of the initial health assessment are described below.

1. History — personal and medical

The collection of personal and medical history usually starts well before a detention health service provider begins a formal initial health assessment. Information from a range of sources, including family members, Australian Government Department of Immigration and Citizenship (DIAC), Australian customs service, police and correctional services, may provide invaluable context about the recent experience of a person in detention, which could shed light on their physical or mental health status.

When an initial health assessment begins in an immigration detention centre, a more detailed personal and medical history is collected to provide context for health assessments. For example, information about a person's country of origin or experiences on their way to Australia may trigger torture and trauma screening. Information about a person's previous medical history (such as diabetes) can likewise indicate a need for more targeted diagnostic interventions.

2. Physical examination

All people entering immigration detention are physically examined. As a minimum, this includes standard checks to establish a health baseline (for example, blood pressure, weight, height, heart sounds, urinalysis and a brief assessment of dental hygiene). Depending on country of origin, method of arrival and previous medical history, more detailed physical examinations may be conducted, including examination for signs of previous torture (for example, burns and other scarring).

3. Targeted diagnostic interventions

Information gained from the collection of personal and medical history and the physical examination determines the need for targeted diagnostic interventions, such as random glucose, chest auscultation and peak flow readings. In some cases, membership of a group informs or dictates targeted diagnostic interventions. One example is the mandatory referral of illegal foreign fishers to state health services for public health screening for communicable diseases.

4. Formalised mental health screens

In response to the recommendations of the Palmer and Comrie reports, an enhanced model of mental health care was developed for use in immigration detention centres. A brief description of this model is provided in Appendix B (Enhanced model for mental health care).

At the time of publication of this framework, key components of mental health care are under review by the Detention Health Advisory Group, including the methods for screening mental health problems and measuring outcomes over time. Instruments will be reviewed for use with people from different cultural backgrounds and will include specialised screens for torture and trauma.

7.3 Treatment plan

Treatment management is coordinated through a general practitioner for all people in immigration detention who have a need for ongoing medical treatment. In more complex cases, this may take the form of a formal written treatment plan. Less complex cases may not require a formal treatment plan; however, all cases will include accurate and comprehensive record keeping, and coordination. Coordination is supported in facility-based detention by clinic staff who schedule and follow up appointments, medication needs and referrals to external services, and also coordinate any escorts for offsite visits. Clinic staff liaise with the relevant general practitioner to record estimated treatment regimes, date of next review and any external referrals or other support needs.

7.4 Ongoing health monitoring and response

Some health care needs may not be identified during initial health assessment or they may evolve during the course of a person's period in immigration detention. Successful identification of emerging health care needs depends on a range of factors, such as developing trust between people in detention and the range of service providers involved in immigration detention. It may also depend on referral by family members or other people in detention, and on formal monitoring processes, such as three-monthly mental health screening. Identifying emerging health needs must be followed by an effective response, including access to appropriate health care and review of detention placement options to ensure that people are accommodated in the most appropriate setting.

7.5 Discharge health assessment and planning

A discharge health assessment will be completed for each person discharged from any immigration detention placement. The purpose of the discharge health process is to ensure that clients discharged from immigration detention have some continuity of health care in either their country of origin or in the Australian community.

As with all health services provided in immigration detention, discharge assessments will be tailored to the health risk factors that exist for an individual. While an initial health assessment includes certain mandatory assessment processes, discharge assessment may take different forms depending on the person's history and health status, ranging from a review of a person's health record to determine their health for discharge, to a more thorough assessment and a physical medical examination. The Health Services Manager will offer a physical examination to any person in detention who will be travelling overseas by aircraft, unless a physical examination certifying fitness to travel has been done in the 28 days before discharge, and a physical examination is not clinically necessary. For people being discharged to live in the community, a physical examination will be offered if the health service provider recommends it, but is voluntary and cannot delay the discharge.

Where clinically indicated, the discharge assessment and planning process will also include:

- discharge medication for a minimum of seven days
- a discharge summary of the medical treatment a person has received while in immigration detention
- a clinical handover or referral for future health service providers.

The discharge summary will inform future health service providers of relevant health history, treatment received during detention, any ongoing treatment regimes and any critical incidents that occurred during detention, including relevant investigation results. In some situations, the discharge summary will be translated to the person's nominated language.

The person may also need ongoing medical and social welfare support after discharge. The Health Services Manager should bring these matters to the attention of the relevant departmental manager as early as possible so effective discharge planning can be started. Contact may be made with the relevant health service providers in Australia or overseas, as identified in partnership with the person, to ensure continuity of care.

Details of DIAC's health discharge assessment policy and process are provided in Appendix C (National detention health policy: health discharge from immigration detention).

This chapter provides an overview of the Australian Government Department of Immigration and Citizenship's (DIAC) approach to achieving and continuously improving the quality of health care for people in detention.

8 Quality in health service delivery

8.1 Defining quality in health care

A Victorian framework for quality in health care adopts the following six dimensions of quality:²³

- **Safety** — the safe progress of consumers through all parts of the system by reducing risk and harm arising from care.
- **Effectiveness** — the extent to which treatment, intervention or service achieves the desired outcome.
- **Appropriateness** — the expected health benefit exceeds the expected negative consequences by a sufficiently wide margin that the procedure is worth doing. Appropriateness relies on using the evidence to do the right thing to the right patient, at the right time, avoiding over and under use.
- **Acceptability** (sometimes called consumer participation) — the degree to which a health service meets or exceeds the expectations of informed consumers. Acceptability requires that health consumers participate collaboratively with the health organisation and service providers at all levels of service planning, delivery, monitoring and evaluation, in a dynamic and responsive way.
- **Access** — equitable access to health services for the population they serve on the basis of need, irrespective of geography, socioeconomic group, ethnicity, age or sex.
- **Efficiency** — health resources are used to achieve value for money.

Quality is also expressed in terms of the nine dimensions of health system performance described in the *National Health Performance Framework* and summarised in Table 8.1.²⁴

The dimensions of quality in the detention health setting are no different from those relevant to any health service. However, the detention environment has several features that make it difficult, yet critical, to achieve quality. These features include a high degree of cultural and linguistic diversity; the fact that immigration detention involves an involuntary restriction of freedom; the uncertainty that people in detention experience about their futures; and the elevated levels of risk people bring with them through past experiences.

The remainder of this chapter describes how DIAC seeks to provide quality health care in the detention health environment.

²³ Summarised from Victorian Quality Council (2005), *Better Quality, Better Health Care — A Safety and Quality Framework for Victorian Health Services*, Victorian Department of Human Services, Melbourne.
www.health.vic.gov.au/qualitycouncil/pub/improve/framework.htm

²⁴ National Health Performance Committee (2001). *National Health Performance Framework Report: A Report to the Australian Health Ministers' Conference*, Queensland Health, Brisbane, 8.
www.health.qld.gov.au/nathlthrpt/performance_framework/11381_doc.pdf

Table 8.1 Dimensions of health system performance

| | | |
|---|---|---|
| Effective | Appropriate | Efficient |
| Care, intervention or action achieves desired outcome. | Care, intervention or action provided is relevant to the person's needs and based on established standards. | Achieving desired results with the most cost-effective use of resources. |
| Responsible | Accessible | Safe |
| Service provides respect for people, is client orientated, and includes respect for dignity, confidentiality, participation in choices, promptness, quality of amenities, access to social networks and choice of provider. | Ability of people to obtain health care at the right place and right time, irrespective of income, physical location and cultural background. | The avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered. |
| Continuous | Capable | Sustainable |
| Ability to provide uninterrupted, coordinated care or service across programmes, practitioners, organisations and levels over time. | An individual's or service's capacity to provide a health service based on skills and knowledge. | A system or organisation's capacity to provide infrastructure, such as workforce, facilities and equipment, and be innovative and respond to emerging needs (such as research or monitoring). |

8.2 Effective governance

Effective governance refers both to corporate and clinical governance structures and activities (see also Section 4.2.4, Effective governance). This section discusses the new contractual arrangements that define responsibilities and set performance measures for delivering health services for people in immigration detention; and describes the various governance bodies and process that operate in the detention health environment.

8.2.1 New contractual arrangements for next generation detention services

At the time this framework was written, DIAC had started a tender process to introduce new contractual arrangements for detention services (see also Section 1.2.4, Implementing the framework). Following extensive community and industry consultations, the following three tenders were released in May 2007 for the provision of the next generation of detention services:

- *Provision of Detention Services in relation to People in Detention at Immigration Detention Centres*
- *Provision of Detention Services in relation to People in Detention at Immigration Residential Housing and Immigration Transit Accommodation*
- *Provision of Health Services in relation to People in Detention.*

The new contractual arrangements are expected to be in place in 2008. Many of these arrangements, such as the various governance bodies described below, are already in place with the current health service provider. The new contractual arrangements will strengthen existing governance mechanisms and introduce new requirements to continuously improve the quality of detention and detention health services.

The scope of the health services tender reflects the principles of this framework and the service delivery model developed to provide the philosophical underpinnings of the new contractual arrangements for detention services.²⁵ The tender process will establish rigorous contractual arrangements that will, for example, assign clear responsibilities for various aspects of health service provision and provide a performance-based framework that rewards high standards of service delivery.

Section 8.3.1 (Formal detention health standards) provides more information on the development of standards of health service delivery in the detention environment.

²⁵ www.immi.gov.au/about/contracts-tenders/detention-services/_pdf/SDM.pdf

8.2.2 Governance bodies

The delivery of integrated, coordinated and effective health care to people in detention requires a high degree of cooperation between DIAC, the Health Services Manager, detention service providers and relevant stakeholders. Corporate governance arrangements that support this operate at national, regional and site levels.

Two main governance bodies operate at the national level:

- **Health Contract Management Group**

The Health Contract Management Group oversees the contract process and manages overarching policy communication. The group also provides a forum to address finance-related issues. One of the group's main functions is to review issues associated with the overall delivery of health services to ensure the services are provided as specified in the contract. The group also ensures any variations are handled quickly to respond to emerging needs. The Health Contract Management Group comprises representatives from DIAC and the Health Services Manager, and will convene quarterly.

- **Health Services Delivery Group**

The Health Services Delivery Group provides communication between DIAC, the Health Services Manager and detention service providers (where applicable) about the development, management and delivery of health services to people in detention. Separate subcommittees of the Health Services Delivery Group may be established to deal with issues and other matters specific to a region. The Health Services Delivery Group includes representatives from DIAC and the Health Services Manager. The detention services providers, the Immigration Detention Advisory Group and the Detention Health Advisory Group participate as interested parties. The Health Services Delivery Group meets on a six-weekly basis and reports to the Health Contract Management Group.

To ensure integration between the national and regional or site levels, and between DIAC, the Health Services Manager and the relevant detention service providers, DIAC has developed a centre management model. Under this model, each immigration detention centre has a departmental centre executive who has the authority to manage their centre and to coordinate activities with partners and stakeholders at the local and national level. At other immigration detention facilities (immigration transit accommodation, residential housing), the position is called the 'departmental site executive'.

The following governance bodies operate at a regional and site level.²⁶

- **Facility board meeting**

All service providers, including the Health Services Manager (represented by the health services regional manager), the detention services provider and the relevant department centre executive or department site executive meet on a monthly basis. The facility board meeting is a forum to discuss facility level objectives, resolve facility level issues, review reports and discuss future plans.

²⁶ These governance bodies are currently in operation and are expected to remain during the transition to the new contractual arrangements in the first half of 2008. However, they are subject to review and continuous quality improvement.

- **Prevention Committee**

The Prevention Committee is a multidisciplinary committee comprising representatives of DIAC, the detention service provider and the Health Services Manager, aimed at ensuring the welfare and wellbeing of people in detention in an immigration detention centre, and reducing the risk of serious self-harm or suicide of those people in detention. The role of the Prevention Committee is to identify and take action to minimise harm to any person in a detention facility identified as being 'at risk'. The Prevention Committee meets at least fortnightly.

- **Weekly department review**

At DIAC's request, the Health Services Manager's regional manager participates in a centre or site review meeting. The weekly department review includes the department centre management, other service providers (including the relevant detention service providers) and, where required, the Health Services Manager.

The governance bodies described above are augmented by two consultative groups at each immigration detention centre: a community consultation group and a detainee consultative committee. These groups provide valuable feedback to ensure that services are meeting the needs of the current detention population. They are described in Chapter 9 (External scrutiny and community engagement).

All governance bodies and consultation groups must adhere to privacy requirements governing the exchange of personal health information about people in detention.

8.2.3 Clinical governance

The term 'clinical governance' is used frequently in health care literature. Clinical governance is defined by the Australian Council on Healthcare Standards as:

... the system by which the governing body, managers and clinicians share responsibility and are held accountable for patient care, minimising risks to consumers and for continuously monitoring and improving the quality of clinical care.²⁷

This definition captures the need for good governance at all levels of management and service delivery and illustrates the critical role of continuous quality improvement.

Contractual arrangements under the new detention health tenders require the Health Services Manager to develop, implement and manage a system of clinical governance for the delivery of health services across the detention services network. This system must provide a systematic approach to assuring and improving the standard and quality of health care delivered to people in detention and include the following:

- transparent processes and defined lines of accountability for the overall quality and standard of health care provided to people in detention

²⁷ Australian Council on Healthcare Standards (2004). Clinical governance defined. *ACHS News* 12(Spring):4. www.achs.org.au/pdf/ACHS_News_Spring_2004.pdf

- defined consultation, coordination, information exchange and reporting arrangements between Health Services Manager personnel and health care providers to facilitate and support the performance of the health services
- a comprehensive programme of quality assurance, risk management and continuous improvement activities
- policies and procedures aimed at ensuring consistency in the quality and standard of health care delivered to people in detention across the detention services network.

Critical to the success of clinical governance is clinical leadership by key health professionals who work within the system. Clinical leadership refers both to a set of tasks required to lead improvements in the safety and quality of health care (such as those described in the list above), and the attributes required to successfully carry this out. Clinician input into safety and quality improvement is critical for predicting the 'bedside impact' of changes, and '... is also vital for sustainability of change, as clinicians are often part of the health service over a longer period than managers, with medical consultants, in particular, able to take a long term view'.²⁸ By definition, clinical leadership requires complete clinical autonomy.

8.3 Performance management and continuous improvement

A strategic approach to the delivery of health services in the detention environment must be informed by drawing on, and developing, better information and evidence of what works.

The *Detention Health Framework* recognises the need to identify outcomes that can be measured and monitored, constantly evaluating progress and making necessary adjustments to confirm that health interventions are effective and that the necessary actions are taken to improve future health outcomes for all those in detention situations. This process focuses on all levels, from the efficacy of specific treatments at an individual level through to the effectiveness of protocols and processes involving multiple parties. It relies on formal governance structures, clinical leadership and formal detention health standards, underpinned by data collection to support monitoring of performance against those standards.

Therefore, the service delivery model developed to underpin the new contractual arrangements for immigration detention places a strong emphasis on measuring performance and adapting to change. Continuous improvement mechanisms and performance monitoring tools, which are implemented by both DIAC and service providers, include:

- a combination of 'hard' and 'soft' performance evaluation measures, designed to reflect the wellbeing of people in detention and the service ethos employed
- a balanced set of performance indicators related to organisational mission, values, aims and objectives

²⁸ Victorian Quality Council (2005). *Developing the Clinical Leadership Role in Clinical Governance: A Guide for Clinicians and Health Services*. Victorian Department of Human Services, Melbourne, 2. www.health.vic.gov.au/qualitycouncil/downloads/clingov_clin.pdf

- use of performance data to help drive continuous improvement
- independent reviews and audits to ensure the perspective of people in detention on service delivery and service needs are expressed.

The skills both DIAC and service provider staff need for this are leadership, teamwork, communication, problem solving, observations and questioning, analytical and information technology skills.

An example of a performance management measure is provided in Appendix D (Six-monthly quality performance report [indicative]). This is only one of several performance reporting measures that help to ensure the detention health system is continually improved.

8.3.1 Formal detention health standards

A key element of the performance framework under the new detention health services contract is the requirement that the successful tenderer achieve full accreditation against the Royal Australian College of General Practitioners (RACGP) *Standards for Health Services in Australian Immigration Detention Centres* within 12 months of beginning the contract. The successful tenderer must also maintain this accreditation for as long as they continue to provide health services at any immigration detention centre.

The detention health standards have been developed for DIAC by the RACGP. These standards have been adapted from the RACGP *Standards for General Practices* (3rd edition)²⁹ and customised for use in immigration detention centres.

Accreditation must be carried out by an independent, third-party organisation approved by DIAC, and all health care services delivered to people in detention in immigration detention centres will need to be delivered in accordance with these detention health standards.

Health care services delivered to people in detention outside immigration detention centres, such as people placed in immigration residential housing or immigration transit accommodation, are expected to meet Australian professional standards. For example, general practices must be accredited against the RACGP *Standards for General Practice* (3rd edition) (or any other similar quality assurance requirements approved by DIAC) unless DIAC approves otherwise.

29 Royal Australian College of General Practitioners (2005). *Standards for General Practices*, 3rd edition, Royal Australian College of General Practitioners, Melbourne. www.racgp.org.au/standards

8.3.2 Qualifications, skills and registration requirements for health care providers

In addition to formal detention health standards, the Health Services Manager must ensure that all health care providers involved in delivering health care services to people in detention:

- are appropriately qualified and registered with the relevant registration board, college or other body (and observe any relevant conditions imposed by that registration), before delivering any health care service to people in detention, and maintain their registration as current while they provide any such health care services
- are actively involved in maintaining and updating their professional skills and standards through regular training, activities and courses.

Detention health settings must foster a continuous learning environment that promotes excellence, innovation and clinical leadership in health care delivery. Cultural competence is a critical component of such an environment.

8.3.3 Quality management system

Under the new contractual arrangements, the Health Services Manager must develop, implement and maintain a quality management system that covers delivery of health services across the detention services network. This system must identify and analyse service delivery and other performance issues or failures across the detention services network and contain a systematic process for managing and responding to all identified issues and failures. This system will ensure continuous improvement to service delivery and performance to achieve DIAC's detention health programme objectives and value for money.

The Health Services Manager must report on the outcomes of its quality improvement system as directed by DIAC.

8.3.4 Complaints and feedback

The three-step complaints process, endorsed by the Ombudsman's Office and the Human Rights and Equal Opportunity Commission for people in immigration detention, is as follows:

1. Let a detention services officer know how you feel or fill in an issues form. If you are not happy with their response, try to raise the issue with DIAC centre staff.
2. If you are still not happy, choose any one of the following options:
 - call the DIAC Global Feedback Unit (GFU) toll free on 13 3177
 - write to the DIAC Client Feedback Coordinator, GPO Box 241, Melbourne Vic 3001
 - write and fax the complaint to the GFU on a dedicated feedback fax: 1300 728 402
 - where the internet is available, email Feedback@immi.gov.au.

3. If you are unable to resolve your issue or complaint through the GFU, contact:

Commonwealth Ombudsman
 GPO Box 442
 Canberra ACT 2601
 Ph: 1300 362 072



the Human Rights and Equal Opportunity Commission (HREOC)
 The Director Complaints Handling, HREOC
 GPO Box 5218
 Sydney NSW 2001
 Complaints Infoline: 1300 656 419

Figure 8.1, below, is a poster displayed prominently in all immigration detention facilities and illustrates DIAC's strong emphasis on encouraging clients to make complaints where they are dissatisfied with any aspect of the department's services.

Figure 8.1 'It's OK to complain' poster for immigration detention

Australian Government
 Department of Immigration and Citizenship

IT'S OK TO COMPLAIN

If you are not happy with a service or believe you have been treated unfairly.
 In Australia, you have the right to raise issues and make complaints. The Department of Immigration and Citizenship (DIAC) welcomes your comments, suggestions and complaints. Your feedback will help us improve the quality of our information, products and services.

WHAT CAN COMPLAINTS BE MADE ABOUT?

- FOOD
- MEDICAL OR HEALTH
- PROPERTY
- CLOTHING AND FOOTWEAR
- VISA ISSUES

or anything else

HOW DO I COMPLAIN?

STEP 1
 Let a detention services officer know how you feel or fill in an issues form. If you are not happy with their response you can raise it with DIAC detention centre staff.
If you are still not happy...

STEP 2
 You can call the **DIAC Global Feedback Unit (GFU) toll free on 133 177**, write to the **DIAC Client Feedback Co-ordinator** or complete an online feedback form via the DIAC website: www.immi.gov.au/contacts/forms/services/index.htm.
If you are not happy with the outcome of Step 2 you can take the matter further...

STEP 3
 If you are unable to resolve your complaint with a detention services officer and/or DIAC you can contact the Office of the Commonwealth Ombudsman or Human Rights and Equal Opportunity Commission (HREOC).
For contact details, see below

Translating and Interpreting Service (TIS)
 Phone: 131 459
 DIAC Client Feedback Co-ordinator
 GPO Box 241
 MELBOURNE VIC 3001

The Office of the Commonwealth Ombudsman
 Phone: 1300 362 072
 Fax: (02) 8249 7829
 Letters: Commonwealth Ombudsman
 GPO Box 442
 CANBERRA ACT 2601

Human Rights and Equal Opportunity Commission (HREOC)
 Complaints Infoline: 1300 656 419
 Fax: (02) 6284 9811
 Letters: The Director Complaints Handling
 Human Rights and Equal Opportunity Commission
 GPO Box 5218
 SYDNEY NSW 2001

people our business

Processes for managing complaints and feedback about detention health services are important not only from a quality and service improvement perspective, but also for building and maintaining relationships of trust and confidence between people in detention, the Health Services Manager and health care providers. These systems should promote and support open communication, without any fear of negative repercussions, and demonstrate the Health Services Manager's commitment to learn from, and improve on, any identified performance or service problems or concerns.

The Health Services Manager must develop, implement and manage a system that allows people in detention to make a complaint or provide feedback on any matter relating to the health services. This system must manage, respond to and attempt to resolve complaints or feedback in a responsive, fair, open and timely manner. Requirements for a health complaints mechanism included in the detention health tender are included in Appendix E (Requirements for a health complaints mechanism).

8.3.5 Feedback from health care providers

The Health Services Manager must establish, implement and manage a system that enables any health care provider to raise, in confidence and without prejudice to their position or fear of negative repercussions, concerns over any aspect of service delivery, treatment, care or management of any person in detention. The Health Services Manager must notify DIAC of any concerns notified by a health care provider and, at the department's option, work cooperatively with DIAC and the relevant health care provider in an attempt to address those concerns.

8.4 Establishing an evidence base

Decisions based on sound evidence are most likely to achieve safety, effectiveness and appropriateness. Evidence-based decision making depends on the availability and use of accurate health data and on sound research to inform health care policy and practice.

8.4.1 Health database

Delivering health care depends heavily on a diverse and complex range of information from a large number of sources. Collection, analysis, reporting and communication of health information are critical for appropriate, safe and effective health care practice. To support this, DIAC has commissioned the development of a health database to be derived from the health care records of the current population of people in detention. The database will support reporting on the demographics and health status of people in detention over time. The information being used is de-identified and the work is being undertaken with ethics approval from the appropriate university.

Currently, DIAC lacks a comprehensive morbidity database. To better understand the health issues of people in detention, the department has commissioned an external health research partner to improve the management of morbidity data. The project will include coding and analysing approximately 6000 health records, developing a detention health database, and providing advice on how the database can be used to derive information about the characteristics and health status of people held in immigration detention under the *Migration Act 1958*. The project is scheduled to provide an initial data set in July 2007 and a final report in December 2007. The period to be surveyed is 1 July 2005 to 30 June 2006.

The final report will provide the following key pieces of information:

- the characteristics of people in detention, including age, gender, ethnicity, country of origin (or proxy such as citizenship), language(s) spoken, marital status, period spent in Australia, reason for being detained and duration of detention
- a description of the health status of people when they enter immigration detention and when they leave immigration detention
- the level of health services use, including a unit cost, of people in detention.

The department will collaborate with the Detention Health Advisory Group and its sub-groups to develop a future research agenda for detention health when this work is complete. This will support clinical leadership by providing a sound basis for continuous improvement.

8.5 Other important aspects of quality

So far, this chapter has focused on the more easily measured aspects of quality: effective governance, performance management, continuous improvement and the creation of an evidence base. However, the nine dimensions of health service performance described at the beginning of this chapter also require health care to be appropriate, responsive and continuous. These demand other important practices such as privacy and confidentiality, excellence in communication, consumer participation, continuity of care, and reliable health record keeping.

Some key issues of quality are summarised in the following sections.

8.5.1 Privacy of personal health information — a difficult balance

People in immigration detention are entitled to the same standards of privacy and confidentiality as the general Australian population. DIAC treats privacy seriously and requires health providers and other personnel to seek and share personal health information only after informed consent has been given, where there is a need to know, and for the purposes consented to. DIAC is also conscious, however, that the Palmer and Comrie reports highlighted a tendency of departmental, health and detention services personnel to misinterpret privacy principles as a barrier to communication in situations where effective communication could have prevented some of the problems under investigation.

As a general rule, departmental and detention service provider personnel are not entitled to access personal health information about people in detention. However, as a person's health may change on a daily basis and health issues may affect the detention placement and duty of care matters, the Commonwealth Ombudsman has advised that the department's duty of care may, on occasion, necessitate a 'need to know'. This is important for allowing DIAC to communicate with the Health Services Manager, other organisations, and the Commonwealth Ombudsman, in a variety of complex situations where decisions about appropriate detention arrangements have to be made.

Consent to access personal health information is a dynamic process and is not necessarily secured by obtaining a signed general consent form on one occasion. Changing health conditions of individuals may necessitate review of consent arrangements for access to a person's health information. Situations may arise where a person withdraws consent or is no longer capable of providing informed consent, is not under guardianship or mental health legislation, and is clinically judged not to be at significant risk to self or others but is acting unusually or raising concerns that are reported to DIAC.

DIAC manages these exceptional circumstances by mandating that all requests for personal health information are coordinated through the Detention Health Branch in DIAC's National Office in Canberra.

People in immigration detention are entitled to access all health information recorded about them.

DIAC's policy on privacy is provided in Appendix F (National detention health policy: client health information).

8.5.2 Communication with people in detention

At the time of the initial health assessment, and on demand throughout a person's time in immigration detention, the Health Services Manager must ensure people in detention are provided with relevant written information about the range of available health care services. In each case, this information must be provided in a form the person can easily understand and include the following:

- clear and unambiguous information on the range and type of health care services available, and how and when a person in detention may access them
- an explanation of the arrangements the Health Services Manager has put in place for interpreters
- an explanation of how people in detention may provide feedback or submit a complaint to the Health Services Manager about any health care-related issue or matter
- the Health Services Manager's policy on the use and treatment of personal health information, including when, and for what purposes, DIAC may request and use a person's health information.

8.5.3 Communication between the Health Services Manager, DIAC and the detention services provider

Providing appropriate care and services to people in detention is a multidisciplinary task and can only be achieved through the productive working relationships between DIAC, the Health Services Manager, the detention service providers and relevant stakeholders. Central to these relationships is open and timely communication of all relevant information and early notice of any health-related issues and concerns affecting the care or wellbeing of people in detention.

Subject to privacy laws, the Health Services Manager must advise DIAC about health concerns that affect the management and care of people in immigration detention. This is particularly important when any health care provider has serious concerns about managing a person's health care needs within their current immigration detention placement.

At the request of DIAC or the detention service provider, the Health Services Manager must provide training, education and advice on health concerns or issues relevant to the care, management or placement of people in detention.

The health service provider must provide a 24-hour national health advice line for:

- departmental and detention service provider personnel across the detention network, to provide advice about any person detained in a facility, including the full range of alternative and community detention placements
- compliance officer supervisors who locate unlawful non-citizens with suspected health issues in the Australian community
- departmental personnel working at international airports where there are concerns about the health or wellbeing of any person refused entry and detained at an airport.

8.5.4 Patient rights and responsibilities

The Health Services Manager must put in place appropriate systems and processes that allow people in detention to make health care-related requests. These systems and processes must ensure the following:

- If a person in detention requests a second medical opinion, the opinion is generally obtained only where it has been clinically recommended or the person has agreed to meet the total costs (including transport and escort) of obtaining that opinion. There may, however, be reasonable exceptions to this where the person in detention should not have to bear the cost; for instance where a general practitioner's opinion is reasonably contested or where a third opinion would shed light on conflicting advice.

- If a person in detention requests a service, treatment or procedure outside the scope of the detention health services contract, the person is advised that the requested service, treatment or procedure is only available where they have agreed to accept the risks and meet the total cost (including transport and escort) of that service, treatment or procedure.

Most states and territories in Australia have developed or are developing charters that explain what people can expect when using health services, as well as their responsibilities in relation to obtaining those services. DIAC will develop, publish and make available a formal patient charter for all people in immigration detention.

8.5.5 Continuous and coordinated care

If a person in detention requests to be seen or treated by a particular health care provider (whether by name or gender), every reasonable effort is made to accommodate that request within the Health Services Manager's established network of primary health care providers.

To ensure that people in detention have coordinated, integrated and consistent health care during each episode of care and for the duration of their immigration detention, the Health Services Manager must:

- develop and implement appropriate policies and processes for the timely, complete and lawful exchange of all relevant information between treating health care providers as part of the handover or transfer of care for people in detention (for example, across one or more places of immigration detention)
- take leadership in arranging, coordinating and ensuring delivery of all clinically appropriate follow-up care for people in detention following referral to any specialist, hospital or offsite health care provider.

The delivery of coordinated quality and safe health care will be supported by the Health Services Manager developing and implementing effective records management policies and procedures.

9 External scrutiny and community engagement

Immigration detention is one of the most highly scrutinised of all Australian Government programmes. The Australian Government Department of Immigration and Citizenship (DIAC) is accountable for all its actions to the Australian Parliament and is subject to regular parliamentary scrutiny. In addition to the parliament, there are a number of key external stakeholders who monitor the conduct of immigration detention or provide valuable input to shape the evolution of detention services. This chapter briefly outlines some of the important external stakeholders and how DIAC engages with them.

9.1 The Human Rights and Equal Opportunity Commission

The Human Rights and Equal Opportunity Commission (HREOC) administers a number of Commonwealth laws that implement Australia's obligations under certain international human rights and anti-discrimination instruments. HREOC's structure and functions are described in the *Human Rights and Equal Opportunity Commission Act 1986*. HREOC monitors Australia's immigration legislation and policy for compliance with human rights and anti-discrimination legislation, and has in the past inspected detention centres, evaluating the conditions and treatment of people in detention. HREOC may receive and investigate complaints lodged by people in detention.

9.2 Commonwealth (and Immigration) Ombudsman

The Commonwealth Ombudsman has the power to investigate action relating to a matter of administration by a government department or prescribed authority to see whether they are wrong, unjust or discriminatory. The ombudsman may launch investigations in response to a specific complaint or of its own volition (called an 'own motion'). The ombudsman is independent and impartial, and works to improve public administration. As a result of changes in 2005, the Commonwealth Ombudsman is also referred to as the Immigration Ombudsman and has an expanded role including assessing long-term people in detention and reporting to the Minister for Immigration and Citizenship accordingly; reviewing cases where detention may have been unlawful; monitoring and inspecting immigration detention facilities and activities; and investigating complaints about services delivered by contractors for, or on behalf of, the Australian Government, such as detention centre operators and detention health services providers.

9.3 The United Nations High Commission for Refugees

The United Nations High Commission for Refugees is an impartial, non-political humanitarian organisation mandated by the United Nations to lead and coordinate international action for the worldwide protection of refugees and the resolution of refugee problems. It liaises with governments on refugee and asylum policy, and advises on best international standards in respect to legislation, policy and procedures. It also monitors the application of the 1951 *United Nations Convention Relating to the Status of Refugees*³⁰ and the 1967 *Protocol Relating to the Status of Refugees*,³¹ investigates individual complaints by asylum seekers in detention, and makes general inquiries into the operation of the immigration detention programme.

9.4 Immigration Detention Advisory Group

The Immigration Detention Advisory Group (IDAG) was formed in 2001 and advises the Minister for Immigration and Citizenship on matters relevant to the detention of unlawful non-citizens in immigration detention centres and alternative detention, with particular reference to the appropriateness and adequacy of immigration detention services, accommodation and amenities. Members participate in community consultative processes and contribute to the development and implementation of key detention programme strategies within the detention reform environment, including infrastructure projects, improved services to people in detention, national stakeholder engagement, detention health, case management and community care, and the tender process for detention and related services. IDAG comprises prominent and respected Australians selected for their expertise and demonstrated commitment to immigration and humanitarian issues.

9.5 Detention Health Advisory Group

The Detention Health Advisory Group (DeHAG) was formed in 2006 and plays a major role in providing DIAC with independent, expert advice on health policy, standards for health care services, data and reporting, and mental health training. DeHAG consists of the key health and mental health professional and consumer group organisations, and is chaired by Associate Professor Harry Minas who is also a member of IDAG. The following organisations participate in DeHAG:

- Australian Medical Association
- Royal Australian College of General Practitioners
- Mental Health Council of Australia
- Australian Psychological Society

30 United Nations (1954). *Convention Relating to the Status of Refugees of 1951*, Treaty Series 189(2545). www.unhcr.ch/html/menu3/b/o_c_ref.htm

31 United Nations (1967). *Protocol Relating to the Status of Refugees of 1967*, Treaty Series 606(8791). www.unhcr.ch/html/menu3/b/o_p_ref.htm

- Forum of Australian Services for Survivors of Torture and Trauma
- Victorian Health Promotion Foundation
- Royal Australian and New Zealand College of Psychiatrists
- Royal College of Nursing Australia
- Public Health Association of Australia
- Australian Dental Association.

The Ombudsman's Office has observer status on DeHAG.

9.6 Community consultation groups

Community consultation groups are in place at each immigration detention facility to foster communication and consultation between DIAC, service providers and local communities. The groups constructively explore and consider issues relating to the range of services, activities and welfare opportunities available to people in detention with a view to enhancing service delivery. Community consultation groups typically comprise an IDAG member acting as chair, the relevant DIAC centre or site executive, the relevant detention services provider's centre general manager, department personnel and representatives from the service providers involved in service delivery, a representative from the Commonwealth Ombudsman, and up to 10 community representatives, as determined by the departmental centre executive. Meetings are held every second month, and minutes taken and distributed to DIAC and the IDAG.

9.7 Detainee consultative committees

In addition to the external stakeholders mentioned above, there is an internal stakeholder group — detainee consultative committees — that influence the detention-related health environment within detention centres. Each immigration detention centre has a consultative committee that meets bimonthly to discuss detention-related issues. Meetings are chaired by IDAG and include representation from DIAC, the detention service providers and local community members. The Health Services Manager will be required to attend these meetings, at the request of DIAC. Meetings are minuted, and sometimes include IDAG and Commonwealth Ombudsman representatives.

9.8 Other important stakeholders

Other important stakeholders include the various state and territory health complaints bodies (for example, the New South Wales Health Care Complaints Commission), state and territory health departments, private hospitals, state and territory guardianship boards and tribunals, and a range of non-government organisations (for example, the Red Cross). DIAC is actively building relationships with these organisations, many of whom are critical partners in achieving the goals set out in Chapter 10 (Detention Health Framework Action Plan 2007–2010).

10 Detention Health Framework Action Plan 2007–2010

The Detention Health Framework Action Plan 2007–2010 describes the activities required to implement the *Detention Health Framework*. All the actions, outcomes and outputs described in the action plan ultimately contribute to the three primary outcomes articulated in the framework, namely:

- policies and practices in relation to health care for people in immigration detention are open and accountable
- 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
- the quality of health services provided to people in immigration detention is assured by independent accreditation.

A list of the Australian Government Department of Immigration and Citizenship's (DIAC) health policies and their current status is included in Appendix G (DIAC detention health policies).

Table 10.1 outlines the actions, outcomes and outputs of the Detention Health Framework Action Plan 2007–2010.

Table 10.1 Components of the Detention Health Framework Action Plan 2007–2010

| Principle | » | Actions | » | Outputs | » | Outcomes |
|-----------------------------------|---|---|---|---|---|--|
| 1. Person-centred approach | » | <ul style="list-style-type: none"> • Embed a culturally competent consumer focus into policy, planning and practice in the detention environment • Provide health services that meet individuals' needs • Support community-based recovery | » | <ul style="list-style-type: none"> • Programme of cultural awareness training for non-clinical staff • New contract arrangements for detention health that embed cultural competency in health service delivery • Health care in a community setting for people in alternative detention • Community-based psychosocial rehabilitation services for people following acute psychiatric admissions | » | <ul style="list-style-type: none"> • Improved health and wellbeing outcomes for individuals • Increased client satisfaction with health services |

Table 10.1 Components of the Detention Health Framework Action Plan 2007–2010

| Principle | » | Actions | » | Outputs | » | Outcomes |
|-----------------------------------|---|--|---|--|---|---|
| 2. Appropriate health assessments | » | <ul style="list-style-type: none"> Review and implement revised health assessment policies and protocols with advice from DeHAG, its sub-groups and other independent experts Support front-line staff to deal appropriately with clients showing potential health problems during initial contact | » | <ul style="list-style-type: none"> Implementation of a revised protocol for preventing self harm Implementation of revised mental health screening processes and instruments (DeHAG Mental Health Sub-group) Implementation of a revised protocol for identifying and managing survivors of torture and trauma Implementation of the revised Discharge Health Assessment Protocol Implementation of a new health induction assessment A 24-hour health information advice line for detention, border control and compliance officers | » | <ul style="list-style-type: none"> Increased detection and early intervention Decrease in unnecessary assessments |

Table 10.1 Components of the Detention Health Framework Action Plan 2007–2010

| Principle | » | Actions | » | Outputs | » | Outcomes |
|---------------------------------|---|--|---|---|---|--|
| 3. Shared responsibility | » | <ul style="list-style-type: none"> Empower people in detention to make informed choices about their own health care Equip non-clinical staff with the knowledge to detect and act on early signs of health problems, particularly mental health problems Provide assertive identification, psychiatric assessment and care for people with serious mental illness | » | <ul style="list-style-type: none"> A patient charter (based on health industry) Comprehensive health information for clients, translated into appropriate languages Training and awareness for non-clinical staff about mental illness and other key health issues (such as pandemic awareness and response) | » | <ul style="list-style-type: none"> Improved health and wellbeing outcomes for individuals Increased detection and opportunities for early intervention |

Table 10.1 Components of the Detention Health Framework Action Plan 2007–2010

| Principle | >> | Actions | >> | Outputs | >> | Outcomes |
|--------------------------------|----|---|----|--|----|--|
| 4. Effective governance | >> | <ul style="list-style-type: none"> • Provide public access to detention health policy • Develop clear agreements with state/territory health agencies to provide pathways of care for people in immigration detention • Promote a health care system based on formal detention health standards that provide a robust foundation to monitor the quality of health service provision in all detention situations • Promote a health care system that focuses on continuous improvement and is responsive to complaints, external scrutiny and expert advice • Increase collaboration with external agencies | >> | <ul style="list-style-type: none"> • Service agreements with state, territory and private hospitals • Accreditation system for detention health standards • New contract arrangements for detention health • New health complaints mechanism • Ongoing stakeholder engagement (DeHAG, IDAG, ombudsman, community consultation groups) • Detention health quality management system • Interdepartmental liaison (for example with customs and fisheries) regarding health management for illegal foreign fishers | >> | <ul style="list-style-type: none"> • Community confidence in the standard of health care provided to people in detention • Pathways of care for people in immigration detention are clear and unambiguous • Continuous improvement of detention health service delivery • Improved health and wellbeing outcomes for individuals |

Table 10.1 Components of the Detention Health Framework Action Plan 2007–2010

| Principle | » | Actions | » | Outputs | » | Outcomes |
|--|---|---|---|---|---|--|
| 5. Evidence-based decision making | » | <ul style="list-style-type: none"> • Collect, analyse and report on detention health data to support evidence-based decision making in the detention health environment • Identify areas where evidence is unclear and undertake research • Align policies and protocols with the best available evidence • Develop new detention health policies and protocols to meet identified gaps | » | <ul style="list-style-type: none"> • An evaluation to measure the effectiveness of the Detention Health Framework • Routine reporting against the detention health data • DeHAG research agenda • Interdepartmental liaison (for example with the Australian Government Department of Health and Ageing) to increase alignment of policy with evidence and national frameworks • An informed position on the management of health care for people in immigration detention with poor previous health care • Public health protocols aligned with evidence-based risk profiles (DeHAG Infections Diseases Sub-group) • New policies on: <ul style="list-style-type: none"> – privacy – client communication – blood-borne viruses – voluntary starvation | » | <ul style="list-style-type: none"> • Decisions at both a clinical and system level are made on sound evidence of what works • Improved health and wellbeing outcomes for individuals |

DeHAG = Detention Health Advisory Group; IDAG = Immigration Detention Advisory Group

Appendix A

Summary of health care arrangements by immigration placement

This appendix summarises the manner in which health services are delivered to people in detention across the detention services network.

The various immigration detention placements listed below are described in more detail in Section 2.4 (Types of immigration detention).

A1.1 Immigration detention centres

The Australian Government Department of Immigration and Citizenship (DIAC) expects the Health Services Manager to organise sufficient clinical consultation time for both registered nurses and general practitioners so that they can complete health induction assessments for people entering an immigration detention centre, attend to their ongoing health care and management, and conduct health discharge assessments. DIAC has specified minimum onsite frequency requirements for delivering nursing, mental health care and general practice services at each centre. DIAC expects that a person in detention would not need to leave an immigration detention centre to receive a routine health assessment (induction or discharge) or ongoing primary health care services.

In addition, DIAC requires the Health Services Manager to make all necessary arrangements with a sufficient and appropriate network of primary health care providers who are able to provide clinically recommended hospital, specialist and allied health services.

The department expects the Health Services Manager to have in place an after-hours, on-call, arrangement for medical advice and response to clinical events that require a primary health care response. However, it should be noted that the relevant detention services provider has responsibility for the initial first aid response to events within their facilities.

The Health Services Manager will work with a health care provider nominated by DIAC in relation to health services on Christmas Island. The Health Services Manager will establish clear channels of communication to facilitate effective liaison and coordination of health services between Christmas Island and the Detention Services Network. The Health Services Manager will be responsible for ensuring that there is a seamless transition between health service providers when people in detention are transferred to or from Christmas Island to either an offshore processing centre or within the onshore Detention Services Network, including ensuring the appropriate transfer of medical records, providing medical escorts and coordinating access to health services as clinically required at onshore destinations. The Health Services Manager will work within the protocols agreed with the nominated health care provider on Christmas Island.

A1.2 Alternative detention

The general principle is that health care for people placed in alternative detention will be accessed from the community and will not involve them entering an immigration detention centre to receive any health care service. Health care arrangements for people in alternative detention is as follows:

- Immigration transit accommodation: DIAC expects the Health Services Manager to make arrangements whereby appropriate health care providers (registered nurses) would provide onsite health induction assessments for people in detention who are new to the Detention Services Network, provide ongoing health management, and manage the health discharge assessment process. However, where there is a need for a medical consultation for any person in detention who has been placed in immigration transit accommodation, the Health Services Manager is expected to have in place a network of community primary health care providers, through which the person in detention could be taken to a general practitioner or other appropriate health care provider.
- Immigration residential housing: immigration residential housing does not have any facilities for providing onsite health care. DIAC expects the Health Services Manager to make appropriate arrangements for all people in detention placed in immigration residential housing to undergo a health induction assessment, receive all ongoing health care and undergo a health discharge assessment from community health care providers.
- Alternative temporary detention in the community: people in detention may also be detained in a variety of other accommodation settings including hospitals, motels or apartments. DIAC expects the Health Services Manager to be responsible for coordinating, managing and providing health care to all people in detention placed in alternative temporary detention in the community. However, if a person in detention is in a hospital, the required health care may be directly provided by the hospital in this instance.

A1.3 Residence determination (community detention)

The Health Services Manager will deliver health care to people in detention living under residence determination (community detention) similar to the way in which it delivers health care services to people in detention in immigration residential housing. That is, people in detention under residence determination (community detention) will access all health care through community-based health care providers under arrangements managed by the Health Services Manager. Given the nature of this form of immigration detention, particular emphasis will need to be given to ensuring that people in detention in residence determination (community detention) are given sufficient and appropriate information about their health care services, and how to access any service.

The general practitioner for a person in detention should be located within a reasonable distance of the person's residential location.

Appendix B

Enhanced model for mental health care

Note: the following description is provided for historical purposes only. These processes and instruments are currently under review by the Detention Health Advisory Group.

From September 2005, the Australian Government implemented a number of improvements to health care, such as the establishment of an enhanced mental health service and an integrated mental health screening programme, and the adoption of standardised mental health screening tools.

Under this model, people entering immigration detention are assessed for mental health concerns. This involves a suicide and self harm assessment done on arrival by the receiving detention services officer, an 'at risk' assessment by the nurse undertaking general health assessment, and a follow up by the professional support services psychologist for anyone exhibiting risk.

In addition to the above mental health assessment processes, initial screening also includes a clinician-rated health of the nation outcomes scale and a mental state examination. All detainees who screen positive on these instruments are referred to a multidisciplinary mental health team for diagnosis, the development of a specific mental health management plan and ongoing mental health care. This team comprises representatives from a pool of mental health nurses, psychologists, senior counsellors, general practitioners and psychiatrists.

All detainees in all centres who screen negative can be reassessed at their own request, at the request of detention service provider staff if any concerns are noted by health personnel, at the request of the Australian Government Department of Immigration and Citizenship or an agreed third party. If not rescreened earlier, all detainees will be rescreened at 90 days to ensure no one develops an undetected mental health disorder.

If the management plan requires inpatient mental health treatment, this will be arranged through clinical pathways developed with identified public and private sector health providers.

Appendix C

National detention health policy: health discharge from immigration detention

Part A: health discharge assessment

1. The health discharge assessment determines a person's health for discharge from detention and the appropriate actions required for the discharge.

The Australian Government Department of Immigration and Citizenship (DIAC) relies on the clinical advice of qualified health professionals undertaking discharge assessments. If a person is recommended as fit for discharge, necessary arrangements will be made for the person's discharge. If a person is not recommended as fit for discharge, DIAC will make appropriate arrangements to support the person's needs towards future discharge.

2. The health discharge assessment is done by qualified health professionals who will consider clinical indicators to assess each person being discharged from immigration detention.

The health service provider will review the medical history of each person being discharged and consider their health care treatment during detention and their current health status to determine assessment requirements for discharge. This will include whether a physical examination is required and who should perform the examination.

3. Discharges between detention placements and locations interstate require a physical health discharge assessment only if a clinical need is indicated.

Generally, a physical health discharge assessment is not required for transfers interstate or between detention placements. The health service provider is required to complete the health transfer papers and may initiate a physical health discharge assessment if clinically indicated.

4. People being removed to their country of citizenship require a physical health discharge assessment to certify their fitness to travel by aircraft.

People being discharged from detention who are travelling overseas require a physical health discharge assessment to certify their fitness to travel by aircraft, unless a physical examination certifying fitness to travel has been performed in the 28 days before discharge and it is not thought to be clinically necessary.

5. People in immigration detention being discharged to live in the Australian community will have a health discharge assessment.

The health service provider will complete a health discharge assessment for people being discharged from immigration detention to live in the community. If the health service provider recommends a physical examination it will be offered to the person but is voluntary and cannot delay the discharge.

6. The health discharge process involves completing a number of steps to ensure appropriate discharge of a person from immigration detention.

In addition to the health discharge assessment policy, the detention health policy on health discharge from immigration detention includes a policy on other aspects of the discharge process, including the provision of a discharge summary, a supply of medications and necessary handover of health information.

This policy will be reviewed after 12 months.

Appendix D

Six-monthly quality performance report (indicative)

This appendix provides indicative content for six-monthly performance reports to be provided by the Health Services Manager to the Australian Government Department of Immigration and Citizenship (DIAC).

Note: These requirements were published in the detention health tender documents released in May 2007 and are indicative only. Details may change following contract negotiations.

The Health Services Manager must submit a six-monthly quality performance report that includes:

- a) details of progress made in identifying and implementing quality improvement activities and initiatives, and any quality and service delivery improvement outcomes achieved during the relevant six month period
- b) information regarding the Health Services Manager status for the purposes of delivering health care services at any centre, including:
 - i. informing the department of the target date for its first or next accreditation review
 - ii. informing the department of the outcome of each accreditation review
 - iii. if full accreditation is not achieved, outlining an action plan for the department's approval to achieve full accreditation or, where an action plan was agreed in a previous period, progress made in implementing the approved action plan
- c) summary details of all incidents reported by the Health Services Manager during the relevant six-month period, and any follow-up action or response taken by the Health Services Manager (or any health care provider)
- d) summary details of all complaints and other feedback received by the Health Services Manager during the relevant six-month period, including by type (for example, person in detention complaint, or health care provider complaint), service category (for example, mental health service, hospital or specialist service), region, details of complaints resolved during the month within 30 days of receipt, and any complaints referred to external dispute resolution bodies
- e) summary details of all material service or performance failures during the relevant six-month period, and any instance in which a person in detention was denied or failed to receive a health care service, including reasons for that failure or denial

- f) details of people in detention health care requests for a second opinion or any treatment or service outside the scope of the contract (and the Health Services Manager response)
- g) a statement of compliance with all relevant laws, professional requirements and a listing of any related investigations or violations (by the Health Services Manager or a health care provider) during the relevant six-month period
- h) summary details of all Commonwealth and Immigration Ombudsman or other stakeholder investigations or reviews, litigation (pending, current or stayed), and other material disputes subject to a dispute resolution process that the Health Services Manager (or any health care provider) is involved in or has participated in, including details of the Health Services Manager or health care provider's involvement or participation.

In addition to the six-monthly quality performance report, DIAC may require more frequent reporting (exception reporting) where the department has serious concerns about the Health Services Manager's performance. The Health Services Manager must satisfy any departmental request for exception performance reporting.

Appendix E

Requirements for a health complaints mechanism

This appendix outlines the responsibilities of Health Services Managers in a health complaints process.

The Health Services Manager must:

- a) recognise and appropriately manage and respond to difficulties people in detention may have in making complaints or giving feedback, for reasons including language or cultural barriers (for example, the system should offer appropriate assistance and alternatives to any person in detention who finds it difficult to submit a complaint or provide feedback in writing)
- b) support and allow people in detention to make complaints or give feedback without fear of negative repercussions, whether through the public and prominent display of relevant information on how people in detention may make a complaint or provide feedback, or the provision of appropriate written material to people in detention
- c) preserve the privacy of people in detention making a complaint or giving feedback
- d) create a detailed record of all complaints and feedback received, noting the date of receipt, name of the person in detention lodging the complaint or feedback, and relevant details concerning the nature of the complaint or feedback. Any complaint or feedback relating to the Australian Government Department of Immigration and Citizenship (DIAC) or a detention services provider must be referred to DIAC or the detention services provider (as applicable), within 12 hours of the Health Services Manager's receipt of the complaint or feedback
- e) within 24 hours of receiving a complaint, provide the person in detention who lodged the complaint with written acknowledgment of its receipt
- f) use reasonable endeavours to resolve the complaint within 10 business days of receiving it, and:
 - i. where the complaint is resolved within that timeframe, immediately on expiry of the 10-day period provide written notice to the person in detention of the outcome or resolution
 - ii. where the complaint is not resolved within that timeframe, immediately on expiry of the 10-day period provide written notice to the person in detention of all further steps and action the Health Services Manager intends to take in an attempt to resolve the complaint

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- g) if any complaint remains unresolved within 30 business days of its receipt, provide written notice to:
 - i. the person in detention of any external complaints agencies or bodies to which the complaint may be referred, and the process that he or she must follow to lodge a complaint with any of those bodies or agencies
 - ii. DIAC of the status of the complaint and all action taken by the health services manager in an attempt to resolve the complaint
 - h) make appropriate use of all feedback and complaints to effect change and continuous improvement in the standard and level of service delivery by the Health Services Manager under the contract
 - i) cooperate and reasonably assist with any investigation or review undertaken by an external complaints resolution body or agency following referral of a person in detention complaint to that body or agency.

Appendix F

National detention health policy: client health information (draft)

1. People in immigration detention are entitled to the same standards of privacy and confidentiality as the Australian population.

Personal health information of all people in immigration detention is private and confidential information between the individual person and the health service provider. The Australian Government Department of Immigration and Citizenship (DIAC) and contractor staff will appropriately manage the health information of people in immigration detention to meet all requirements of the *Privacy Act 1988*.

2. The personal health information of a person under immigration detention cannot be accessed or disclosed to any person without specific consent.

The *Privacy Act 1988* states that personal information cannot be released to a third party without the consent of the person to whom the information relates. If there is a need to access information from a medical record the person should be specifically asked to grant access and disclosure of the required information.

An exception to this is the Commonwealth Ombudsman who has specific powers to access health records of people in detention for the purpose of investigations.

3. Appropriate information should be provided to the person to enable them to make an informed decision on whether they agree to provide consent.

People in immigration detention are entitled to know and understand the reason that information is being sought from their medical record and how that information will be used. Discussion with the person should include explanation of what information is required, why it is required and how it will be used. Details on what will happen if consent is provided or not provided should also be explained to the person.

Appropriate interpreting and translation support should be provided in this discussion.

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4. With the person's specific consent, the health service provider may prepare a summary report of health information from the person's medical record and disclose it to DIAC for the consented purpose.

The health service provider is professionally qualified to understand the medical record and the person's health treatment and status. When consent is granted by the person, the health service provider will review the medical record and prepare a summary report of appropriate information.

All staff provided with a summary report of health information of a person under immigration detention is responsible for only using the information for the consented purpose. This includes not sharing the information with others for different purposes.

5. Requests for, and the provision of health information for people in immigration detention will be coordinated through the Detention Health Branch.

The Detention Health Branch coordinates requests for health information of people in immigration detention to ensure that the need for the request is substantiated and the appropriate consent is granted. The branch also coordinates the preparation of reports by the health service provider and provision of reports to the requesting officer.

Procedures to support implementation of this policy are managed by the Detention Health Branch (detention.health@immi.gov.au).

This policy will be reviewed after 12 months.

Appendix G

DIAC detention health policies

The following list of Australian Government Department of Immigration and Citizenship (DIAC) detention health policies is provided to illustrate the scope of policies developed or under development at 28 June 2007. Health policies are submitted for comment to the Detention Health Advisory Group or one of its sub-groups (Mental Health Sub-Group or Infectious Diseases Sub-Group) during the development process.

| Policy | Description | Status |
|---|---|---------------|
| HIV testing for people under immigration detention | Requirements for HIV testing in detention based on national HIV policy | Final |
| Health discharge from immigration detention: | Requirements for discharge of a person from immigration detention in respect to their health | Final |
| <ul style="list-style-type: none"> • Part A — Health discharge assessment | Requirements for assessing a person's health before discharge from detention, includes fit to fly assessment | Final |
| <ul style="list-style-type: none"> • Part B — Discharge medication | Requirements for supply of medications at discharge, includes amount and time of supply | To be drafted |
| <ul style="list-style-type: none"> • Part C — Discharge summary and handover of health information | Requirements for preparing and providing a health discharge summary for provision to the person being discharged from detention | To be drafted |
| Access to and privacy of health information | Requirements for managing health information of people in detention; includes privacy and consent requirements | Final draft |

| Policy | Description | Status |
|---|--|---|
| People under immigration detention on voluntary starvation | Requirements for supporting people in detention who are on voluntary starvation | To be drafted |
| Management of drug-related health problems | Requirements for identifying people in detention with health issues from drug abuse and managing their health care | Draft |
| Dental care for people under immigration detention | Requirements for the provision of dental care to people in detention including the level of treatment and the location of service delivery | Final draft |
| Health services for people being interviewed for immigration purposes (airports and compliance) | Requirements for identifying health issues of people during immigration interviews and seeking health advice and treatment if necessary | To be drafted after a pilot in Queensland |
| Health induction for people coming into immigration detention | Requirements for health assessments and processes associated with the induction of a person into detention | To be drafted |

HIV = human immunodeficiency virus