

# ASYLUM SEEKER HEALTH AND WELLBEING

SCOPING STUDY

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**ST VINCENT'S  
HEALTH AUSTRALIA**

UNDER THE STEWARDSHIP OF MARY AIKENHEAD MINISTRIES



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# Overview of abbreviations

ABBREVIATION	TERM
AHRC	Australian Human Rights Commission
AMES	Adult Multicultural Education Services
APOD	Alternative Places of Detention
ASAS	Asylum Seeker Assistance Scheme
ASLS	Asylum Seeker Liaison Service
ASRC	Asylum Seeker Resource Centre
ATAPS	Access to Allied Psychological Services
BSL	Brotherhood of St Laurence
BVA	Bridging Visa A
BVB	Bridging Visa B
BVC	Bridging Visa C
BVE	Bridging Visa E
BVR	Removal Pending Bridging Visa
CALD	culturally and linguistically diverse
CAMHS	Child and Adolescent Mental Health Service
CAMS	Community Action for a Multicultural Society
CARAD	Coalition Assisting Refugees After Detention
CAS	Community Assistance Support
CAT	Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment
CATT	Crisis assessment and treatment teams
CERD	Convention on the Elimination of All Forms of Racial Discrimination
CESCR	Committee on Economic, Social and Cultural Rights
CHC	Community Health Centre
CRC	Convention on the Rights of the Child
CSDH	Commission on Social Determinants of Health

ABBREVIATION	TERM
CST	Catholic Social Teachings
DeHAG	Detention Health Advisory Group
DHS	Department of Human Services, South Australia
DIAC	Department of Immigration and Citizenship
ECOSOC	Economic and Social Council
EPIcentre	Emergency Practice Innovation Centre
FASSTT	Forum of Australian Services for Survivors of Torture and Trauma
GP	General Practitioner
HARK	health assessments for refugee kids
HREOC	Human Rights and Equal Opportunity Commission
HSS	Humanitarian Settlement Services
IAAAS	Immigration Advice and Application Assistance Scheme
ICCPR	International Covenant on Civil and Political Rights
ICERD	The International Convention on the Elimination of all Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDC	Immigration Detention Centre
IDF	Immigration Detention Facility
IHMS	International Health and Medical Services
IMA	Irregular Maritime Arrival
IMR	Independent Merits Review
IRH	Immigration residential housing
ITA	Immigration transit accommodation
MDA	Multicultural Development Association
MOU	Memoranda of Understanding
NASAVic	Network of Asylum Seeker Agencies in Victoria
NSW	New South Wales
OPCAT	Optional Protocol to the Convention of Torture
PBS	Pharmaceutical Benefit Scheme

ABBREVIATION	TERM
PPV	permanent protection visa
PTSD	post traumatic stress disorder
QLD	Queensland
QPASTT	Queensland Program of Assistance to Survivors of Torture and Trauma
QTMHC	Queensland Transcultural Mental Health Centre
RCH	Royal Children's Hospital
RCOA	Refugee Council of Australia
RHeaNA	Refugee Health Network of Australia
RHN	Refugee Health Nurse Refugee Health Network of Australia
RHNP	Refugee Health Nurse Program
RHS	Refugee Health Service
RRT	Refugee Review Tribunal
SPT	Subcommittee on Prevention of Torture
STARTTS	Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
SVMHS	St Vincent's and Mater Health Sydney
SVHA	St Vincent's Health Australia
SVHM	St Vincent's Hospital Melbourne
SVHS	St Vincent's Hospital Sydney
TIS	Translating and Interpreting Service
TPV	temporary protection visa
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
VFST	Victorian Foundation for Survivors of Torture
VIC	Victoria
VIDS	Victorian Infectious Disease Service
VPT	Victorian Public Transport
VRHN	Victorian Refugee Health Network

# Foreword

St Vincent's Health Australia (SVHA), and specifically the SVHA Group Mission Office and the SVHA National Steering Committee on Asylum Seeker Health and Wellbeing, commissioned this scoping study into the general health and wellbeing needs of, and quality of health care services for, asylum seekers in the community. It forms part of the "Social Justice through Health Program" which is seeking not only to remediate the health outcomes of marginalised persons, but also to bring about deep and abiding change in the conditions in which poverty, vulnerability, injustice, and ill-health are created and maintained. This project report will serve as a background paper for service planning, policy development and to assist SVHA to build an evidence base for its engagement in health services for asylum seekers in the Australian community.

Members of the Emergency Practice Innovation Centre (EPIcentre) and Social Work Department at St Vincent's Hospital Melbourne (SVHM) in collaboration with the Brotherhood of St Laurence embarked on collecting as much information as possible within the short timeframe of three months, and with the generous help of many working in the field of asylum seeker health. This project report, using a "Social Determinants of Health" framework to enable a comprehensive and innovative perspective, includes: an overview of the social determinants of health and full literature review on the health of asylum seekers in Australia; an environmental scan of services available to asylum seekers living in areas of Australia's east coast; and the human rights and policy context impacting on asylum seekers in Australia. Given the ever changing policies regarding asylum seekers, including the handing down of the Report of the Expert Panel on Asylum Seekers (August 2012) that occurred during this scoping study, parts of this report provide merely a snapshot of the situation, while other parts bring together the available data in a unique way that has not previously been available in Australia. Although the scoping study was completed in September 2012, upon release of the report, every effort was made to document relevant policy changes in a fluid policy-making environment.

The original focus of this report was on asylum seekers in the community without Medicare rights, however, it soon became apparent that this group is ever-changing, and that many others are just as vulnerable to health inequalities, thus requiring us to broaden the scope to all asylum seekers living in the community. The difficulties experienced by asylum seekers while living in the country they flee, while travelling to Australia, and while in immigration detention often have long lasting effects on their health and are often carried over to the period they spend in the Australian community. And while the focal point of this report is on mental and physical health, the social determinants framework compels us to take into consideration that visa status, housing, employment and several other factors all have a significant effect on the health of asylum seekers. As this report will show, asylum seekers living in the Australian community are one of the most vulnerable groups and there is significant room to improve their access to health services, and overall wellbeing

# Executive Summary

Australia is one of many countries that receive asylum seekers, fleeing their home country seeking refuge somewhere free from conflict. Only those who are fleeing from persecution for one of five defined reasons will meet the definition of a refugee and have the right to enter (with or without authorisation) and stay in Australia under the United Nations Refugee Convention. According to data from the Department of Immigration and Citizenship, after an extensive determination process, many asylum seekers arriving by plane, and almost all of those arriving by boat, are found to be genuine refugees. They receive permanent protection visas and become part of the society with the same rights and responsibilities other Australians have. However, this determination process often takes up a considerable period of time, sometimes years, during which asylum seekers are awaiting a decision, either in immigration detention or in the community. Asylum seekers already have a higher risk of experiencing a range of illnesses and a more urgent need for health care compared to the rest of the Australian population due to a history of inadequate nutrition, health care and social security supports in the country they fled, chronic stress and/or factors surrounding their journey to Australia. The stress caused by (sometimes lengthy) immigration detention, prolonged uncertainty regarding their visa application, and not having control over their own, or families', living circumstances and futures is substantial. This period of uncertainty in the setting of previous trauma often leads to the development or exacerbation of mental illnesses including Post Traumatic Stress Disorder (PTSD) and depression. In addition, from a "Social Determinants of Health" perspective, asylum seekers are met with either restrictions to, or a failure to improve, almost all of the below domains:

- Income and social status
- Social participation and social support networks
- Education
- Health literacy
- Healthy living conditions
- Racism, discrimination and culture
- Early life factors and genetics
- Individual behaviours and lifestyle factors
- Access to health care

These areas of deficiency highlight ways that Australia is breaching several human rights treaties including the Refugee Convention, and conventions regarding Economic, Social and Cultural Rights, Civil and Political Rights, the Elimination of all Forms of Racial Discrimination, against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and the Rights of the Child.

Thus, asylum seekers are one of the most vulnerable groups in the Australian community and therefore a change is needed in the way we view their rights and welfare. Overcoming the barriers to accessing health care for this population is an urgent starting point. Many have complex mental health needs, need culturally-appropriate services, require an interpreter and have limited resources. Existing health services for asylum seekers are stretched and remain relatively unsupported, operating with very limited budgets and often relying on volunteers and professionals providing pro-bono services.

# Section overview

## Section 1:

A consideration of the health and wellbeing of asylum seekers using a social determinants perspective

## Section 2:

Literature review: health of asylum seekers in Australia

## Section 3:

Environmental Scan: Overview of asylum seeker health services and service gaps

## Section 4:

Identification of the human rights context regarding asylum seekers in Australia

## Section 5:

Overview of Australia's legislation and policies regarding asylum seekers

For the purpose of this report, an **asylum seeker** is anyone who is seeking protection in Australia. The focus of this report is on “onshore asylum seekers”, including those who arrive at an excised offshore place, often by boat, and are permitted by the Minister for Immigration and Citizenship to apply for a Protection visa; or those people who arrived in Australia with a substantive (valid) visa, often by plane, and have applied for a Protection visa. A person remains an asylum seeker during the primary or merits review process, until they are found to be a refugee. Humanitarian appellants are individuals who have not been found to meet the criteria of a refugee or the complementary criteria and are appealing for the Minister of Immigration and Citizenship to personally intervene and reconsider their request on other exceptional, humanitarian grounds. For the purpose of this report they will still be considered asylum seekers.





## Section 1:

A consideration of the health and wellbeing of asylum seekers using a social determinants perspective

# Summary section 1

Using a social determinants framework, this section considers the social and environmental influences that help to understand the breadth of issues impacting on the health status of asylum seekers. Here the interrelationships between a lack of income, dependence on others, experience of discrimination, difficulties accessing education and housing, pre-migration trauma and illness and limited supports and rights illustrate a cycle of deprivation for this population. This cycle begins prior to migration but is maintained and in many cases exacerbated by the limitations of support, resources and rights offered in Australia. The result of this trail of deprivation is a group of traumatised individuals who often remain on the fringe of society; experience ongoing discrimination, poverty, exclusion, substandard living conditions; and experience physical and mental health issues more frequently than the general population. In short, asylum seekers are some of the most vulnerable people in our society with major physical and mental health needs that are unmet.

## Introduction

This section begins with an exploration of health and illness as a concept, and considers how social and environmental factors influence health and wellbeing, and contribute to health inequalities within a population. Calling upon a 'Social Determinants of Health' model by Cannon, a framework is applied to examine the specific factors influencing the health and wellbeing of asylum seekers in Australia. Case examples and quotes demonstrate the lived experiences of asylum seekers and illustrate the impact of detrimental policies.

## How we understand health and illness

When considering the health and wellbeing of a particular group of people it is important to use a framework that is theoretically based. The way that health and illness have been understood has changed extensively throughout history. While the mind and body was considered inextricable linked to the way we understood wellbeing prior to the 16th Century, with increased understanding of science, a separation of these components became the norm and the curing of illness became a matter of science alone.

In the 1960s Engel, a social scientist, began to challenge what he called the reductionist, dualist nature of the biomedical model and emphasised the need to consider the experience of illness as a bio-psychosocial occurrence that involves the whole person<sup>1</sup>. Engel argued that people were not just humans but living beings who are impacted by psychological and sociological settings. By 1995, Koenig had suggested the need to broaden this focus to also include a spiritual component<sup>2</sup>.

More recently a conceptual shift has enabled us to understand the importance of the *social determinants* of health, "the conditions in which people are born, grow, live, work and age and including the health system"<sup>3</sup>. This perspective notes the sensitivity of health to the social environment, and brings a new complexity to our understanding of health and wellbeing – especially in relation to discrepancies amongst populations<sup>4</sup>. "It is not simply that poor material circumstances are harmful to health" Wilkinson and Marmot state, "the social meaning of being poor, unemployed, socially excluded or otherwise stigmatised also matters."<sup>5(p.9)</sup>

Social determinants explain inequalities of health *within* and *between* communities and countries. The 20-year life expectancy gap between Indigenous and non-Indigenous people in Australia for example, cannot be explained simply in relation to economics without an understanding of the influence of a wide range of factors<sup>6</sup>. The World Health Organisation (WHO) includes the following list in its description of the social determinants of health<sup>5</sup>:

- the social gradient
- stress
- early life
- social exclusion
- work
- unemployment
- social support
- addiction
- food
- transport

These factors present a multifaceted web of social and environmental influences that assist in explaining health discrepancies and directing policy makers in their response to such discrepancies. Thus, the WHO’s Commission on Social Determinants of Health (CSDH)<sup>3</sup> suggests three overarching recommendations in response to the inequities of health outcomes:

- Improve daily living conditions
- Tackle the inequitable distribution of power, money, and resources
- Measure and understand the problem and assess the impact of action

These recommendations illustrate the complexity of both the *causes* of health inequalities and the *responses* required to address them. Given the almost universal experience of disadvantage that asylum seekers in Australia encounter, a social determinants perspective will enable a comprehensive understanding of their health needs.

## Social exclusion

Inextricable to the role of social determinants in relation to health is the exclusion of those living in disadvantaged situations from the wider society. In particular, this aspect of disadvantage impacts directly on access to services but also has broader implications. Having access to fewer economic resources directly impacts on the amount of social participation that can be enjoyed and leads to ‘social exclusion’. Social exclusion is ‘the failure of society to provide certain individuals and groups with those rights and benefits normally available to its members, such as employment, adequate housing, health care, education and training, etc’<sup>7</sup>. Kawachi and Berkman<sup>8</sup> show the breadth of the impact of ‘social exclusion’ to include restrictions around consumption, production, political engagement as well as social interaction (see Table 1).

**Table 1: The impact of social exclusion**

WAYS THAT SOCIAL EXCLUSION IMPACTS ON INDIVIDUALS LIVES <sup>8</sup>	
Consumption	The incapacity to purchase goods and services relative to need
Production	A lack of participation in economically or socially valued activities
Political engagement	A lack of participation within government processes
Social interaction	A lack of connectedness to family, friends and the community in which one lives

The impact of social exclusion then, encompasses a person’s access to work, support services, connection to family, friends and community as well as their ability to manage personal crises and to have their needs and concerns recognised<sup>9</sup>.

## Avoidable differences

While social exclusion and economic inequities are linked they cannot be totally explained by each other. Indeed, decisions about *what* resources are needed to relieve material deprivation as well as *who* gets these resources are socially determined<sup>10</sup>. Thus, while considered a Right according to the Universal Declaration of Human Rights<sup>1</sup>, being able to participate in society, connect to and support others, maintain a role, claim a status, access support and feel a sense of belonging, is in fact not available to all. This denial to simply be a part of the way of life experienced by others has a broad impact and can be socially and psychologically damaging, costly as well as being harmful to health<sup>12</sup>.

Thus health and wellbeing is influenced not only by the individual genetic makeup of a person but the social factors they are subject to. These social factors influence not only physical health but access to a wider social world, to a sense of belonging and to an overall sense of wellbeing.

## Framework

Given the scope of these factors a framework will guide the consideration of the specific determinants influencing the health and wellbeing of asylum seekers in Australia. For the purposes of this document, Cannon’s model of social determinants of health developed for the South Australian Council of Social Service<sup>13</sup>, will be used and will include: the position each person has in the social hierarchy, their financial status, living conditions, social supports, the level of education they have received, acceptance for their race, gender, religion and behaviours and access to health care (see Table 2).

**Table 2: Cannon’s Social Determinants of Health**

SOCIAL DETERMINANTS OF HEALTH	
1	Income and social status
2	Social participation and social support networks
3	Education
4	Health literacy
5	Healthy living conditions
6	Racism, discrimination and culture
7	Early life factors and genetics
8	Individual behaviours and lifestyle factors
9	Access to health care

# Social determinants of health for asylum seekers

Each of the factors included in Cannon's list of social determinants<sup>13</sup> will be separately considered in relation to what is known about asylum seekers currently living in Australia. Each section will begin with a description of the factor followed by the current status of asylum seekers and a case example or direct quote.

## Income and social status

**All citizens in Australia are subject to an income and social hierarchy that places them in a position within society based on financial resources, that has implications for the choices and resources available to them.**

Most asylum seekers arriving in Australia have few financial resources, receive little financial support and face additional expenses required to settle in this country<sup>14</sup>. As a result, many asylum seekers are forced into a position of dependence and destitution and face severe financial instability.

For some asylum seekers in the community, an assistance scheme was created to provide financial assistance to help them cover their basic living expenses until their application for a protection visa has been determined (see section 5). However, eligibility is dependent on many factors and changes throughout the visa application process. Also, these payments are only 89 per cent of the amount received under the Centrelink Special Benefits, which is at a level below the Henderson Poverty Line<sup>15</sup>. Indeed, the Henderson Poverty Line is not the most current measure of disadvantage as it only measures income. Rather, the concept of social exclusion mentioned previously takes the measurement of disadvantage a step further by considering the numerous, overlapping factors that may exclude a person from society. Poverty alleviation is still a central concern; however, social exclusion provides a multi-dimensional framework that points to a range of factors to be addressed in order to reduce the disadvantage that a person or household may experience. Therefore, by even a basic measure, 89 per cent of Centrelink Special Benefits payments are insufficient to guarantee an adequate standard of living.

Asylum seekers in community detention are not allowed to work and receive a small living allowance, are provided with housing and health care. Of those asylum seekers living in the community who *are* allowed to work, many still cannot obtain a job (and therefore the income required to meet their basic needs) due to barriers and limited opportunities to translate their right to work into a job in Australia. There is an expectation imposed on asylum seekers who are released from detention to quickly become financially self-sufficient, which is based on their ability to secure employment. However, there are direct and multiple impediments to accessing work faced by asylum seekers. These include:

- A lack of access to government-supported vocational education and training. While they can undertake study or training at their own cost, this is usually cost prohibitive
- Exclusion from Commonwealth-funded assistance as they are ineligible for Centrelink and most job seeking assistance
- Gaps in their education and employment history due to the refugee experience
- An inability to effectively navigate the Australian job application system, including writing resumes and online application processes
- A lack of understanding of the local job market and minimal personal networks to access it
- A lack of recognition of their overseas qualification or experience
- A lack of local Australian work experience and hence a lack of understanding of Australian workplace culture

- A lack of understanding of the cultural approaches to employment in Australia, including recruitment and interview practices
- Language and literacy limitations
- A lack of resources such as a car, a driver's licence, travel tickets, appropriate clothes for job interviews, and access to computers
- The stigma attached to asylum seekers as many employers do not know that they have work rights and employers are not willing to take on employees who cannot commit beyond a 3 month period due to the visa renewal system
- Transient housing arrangements
- Physical and mental health issues (see section 2)

The rate of employment participation for refugee and humanitarian entrants after 18 months from the date of arrival is 16 per cent according to statistics provided by the Refugee Council of Australia (RCOA)<sup>16</sup>. This rate is thought to be lower for asylum seekers as refugees on protection visas have access to a range of Commonwealth employment support services. Thus, although some asylum seekers are entitled to work, seeking employment in the face of the challenges listed above is particularly disempowering, especially when long-term unemployment sets in. Many asylum seekers are left to their own devices in a new culture where the employment market is complex and unfamiliar.

Living with few financial resources results in a range of stressors that directly relate to health outcomes. To begin with, the ability to purchase nutritious food, shelter, clothing and transport is limited. A lack of work, for many, also results in a lack of role, position and self-worth and impacts on their place in society. Low social status contributes to a deficiency in relation to empowerment and influence on a person's own life. Additional stress arises from being unable to provide for a family, pay for children's needs or the health care of loved ones. As one asylum seeker expressed; *"Too much thinking about how to pay rent, how to buy food, what about visa situation, and illness. So many problems"*<sup>17(p.190)</sup>.

Those living with chronic health problems find that their health care needs cannot be adequately managed due to lack of income. Accessing care can be influenced by such rudimentary reasons as being unable to fund transport<sup>18</sup>. The ongoing pressure of financial need, reduced lifestyle choices and cumulative debt results in, or perpetuates, poor health, mental health problems and reduces the chances of integration in the long term. It is not just the fact that poor material circumstances are harmful to health and wellbeing, but the *meaning* of being poor and socially excluded reduces the chances of feeling that a person is valued and matters to others. The profound distress experienced by asylum seekers who feel shame at having to rely on handouts, in particular the erosion of their sense of independence, has detrimental effects on their wellbeing. Feelings such as demoralisation and despair are expressed because of their inability to support themselves and their families.

## CASE EXAMPLE /QUOTE

*One single mother from South Asia arrived in 2001 with her three children. Having no income in the first few months, she used her remaining funds before being exempted for ASAS (Asylum Seeker Assistance Scheme) payments. Since her RRT (Refugee Review Tribunal) refusal more than 1 year ago and with her case being in the Federal Court, she lost her entitlement to ASAS. With no income she could not afford to pay for food or rent forcing her and her three children into homelessness and severe poverty. Hotham Mission Asylum Seeker Project has assisted since that time with Basic Living Assistance and housing, though the family has had to move three times in different crisis and church properties.*<sup>19(p.20)</sup>

## Social participation and social support networks

**Social participation relates to: 1) doing an activity in preparation for connecting with others; 2) being with others; 3) interacting with others without doing a specific activity with them; 4) doing an activity with others; 5) helping others; and 6) contributing to society<sup>20</sup>.**

Asylum seekers experience a low social status in Australian society, influenced by their indeterminate visa status and resulting restrictions placed on them. In addition, restricted entitlement to Government funded English classes, limited interpreter services, low availability of resettlement assistance<sup>21</sup>, little to no access to public housing, and being unable to undertake voluntary work that would ordinarily attract a wage<sup>22-24</sup> ensures that this group remains cut off from not only social support but social participation in general<sup>14,25</sup>.

The link between Government restrictions and social participation is eloquently described in the following quotes from two asylum seekers; “Economically a poor person is somebody who has to work very hard to keep up with the daily level, but still he survives. Or, if somebody is a stranger and he hasn’t got a social network, no relatives, pretty new in the country, so he is poor”<sup>26(p.11)</sup>; *“Unemployment is a terrible thing. It’s better to work. First of all to feel as if you are part of the community, you want to contribute to the community”*<sup>23(p.6)</sup>.

A lack of funds for recreation, transport and social activities further isolate asylum seekers from the wider society in which they reside<sup>27,28</sup>. What exacerbates these restrictions further is the uncertainty around how long asylum seekers must live within them. Living a life that is ‘on hold’ inhibits the ability to plan, set goals and develop a sense of hope for the future and belonging to a community. All these factors impede this population’s links with their community and ability to connect with their social world. While a range of non-government organisations provide social support for asylum seekers including parenting support, social events, job seeking assistance and group outings (see appendices C, D and E), many remain isolated and unable to fully participate in society.

## CASE EXAMPLE /QUOTE

*“We are so grateful to the authorities: they rescued us from the ocean at a time when I thought that my wife might die and now they have placed us in the community. But I am not allowed to work to support my family, and that is very hard. We have tried to do everything that’s best for our son – to bring him to safety. But sometimes not knowing what the future holds and having nothing to really do can make our days feel unbearable.” (Iranian asylum seekers in community detention in Melbourne,<sup>29, p.21</sup>)*

## Education

Education is a powerful resource in that it increases the ability of individuals to understand information relevant to their rights and to living a healthy life<sup>30</sup>.

Most asylum seekers will arrive in Australia having experienced, at the very least, a break in their education. Some will have not had access to even rudimentary education in their country of origin due to poverty, war or living transiently as they sought safety<sup>31</sup>. Access to education at a primary and secondary level is available to asylum seekers under the age of 18, but tertiary or adult education is generally not accessible given the fees required<sup>23</sup>.



Many asylum seekers will also not speak English as their first language and many will not speak English at all. Restrictions on access to English classes further exacerbate this situation, especially with poor access to interpreter services<sup>17</sup>. Being unable to speak the language of the host community in which you live impacts on all aspects of life and on adjustment and settlement. Language is a barrier to accessing a range of supports, joining in on social activities, further developing skills and articulating needs. Milosevic et al. found language to be a significant barrier to refugees accessing health services in particular<sup>32</sup>.

## CASE EXAMPLE /QUOTE

*I would really like to work and study. I look at here as if it were Iran. I was not allowed to work or study there. And I had no identity there either. But I feel like my situation is much worse here now, because I am no longer single. I have to provide for my family, but I can't. After a year, we were told that we can study (Iranian asylum seeker in community detention in Melbourne<sup>29</sup>)*

## Health literacy

**Health literacy has been defined as the cognitive and social skills that determine the motivation and ability of individuals to gain access to; understand and use information in ways which promote and maintain good health<sup>33(p.263)</sup>.**

Directly related to education, the ability to read, understand and use information about health, health care and prevention of illness is influenced by *pre*-migration literacy levels<sup>34</sup> and access to interpreters and support *post*-migration. Differences in cultural understandings about health and health practices further impact on health literacy<sup>35</sup> and influence health seeking behaviours<sup>36-38</sup>. The absence of culturally and linguistically diverse health care providers means that poor health literacy is often exacerbated at the service level for asylum seekers<sup>39</sup>.

Health literacy means more than being able to read pamphlets and successfully make appointments. Finding health information, including being able to search for facts and services, consider options and make treatment related decisions requires complex language and understanding. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment<sup>40</sup>.

The Ethnic Communities' Council of Victoria illustrate how, for those with limited English, low health literacy impacts access to health in the following ways<sup>39(p.8)</sup>:

- they are less likely to access the services that they need
- they are less likely to understand issues related to their health
- they are more likely to experience social isolation, which can lead to damaging behaviours and negatively impact physical and mental health
- they are at risk of mismanaging their medication
- they are less likely to have an adequate understanding of health issues

## CASE EXAMPLE /QUOTE

*"I've had no English classes ... It is very uncomfortable because I can't say what I want and when you go to a different country and you can't speak it makes you feel bad, very bad, very uncomfortable" (Asylum seeker)<sup>23(p.7)</sup>*



## Healthy Living Conditions

**Healthy living conditions refers to the circumstances a person or group live in that support or enhance health – at a physical, mental and spiritual level. This concept thus encompasses access to shelter, healthy food, exercise, health care and stress management.**

In light of the limited government-subsidised housing available to asylum seekers in the community, and the reliance on securing accommodation through the private rental market, there are concerns around asylum seekers facing housing crises, due to their limited or no income<sup>24</sup>. Without proof of income, asylum seekers are refused support by housing services because of the misconception that they do not have an exit option to eventually transfer to the private rental market<sup>41</sup>. The majority of asylum seeker housing is provided by church organisations or non-government organisations, and access to the private rental market is out of reach for many. However, this housing provision is not sustainable as it relies on philanthropic and volunteer support and unstable housing stock, and it operates outside any housing standards or guidelines<sup>42</sup>.

These restrictions have detrimental impacts on the standard of living, health and wellbeing of asylum seekers living in the community. With only short-term access to a limited financial safety net, and little chance of earning an income, the safety and wellbeing of asylum seekers is compromised. The policy vacuum into which they fall as a result of their immigration status exacerbates this situation. This can result in poverty, homelessness, anxiety, depression, mental health issues and family breakdown<sup>43</sup>. Given the distress and vulnerability they face, there is concern that asylum seekers will be significantly over-represented in key measures of disadvantage such as homelessness, unemployment and poverty.

Healthy living conditions are also impacted by a lack of help-seeking behaviours such as delays in accessing preventative care including early screening, and routine physical or mental health assessment for asylum seekers post migration which can result in a deterioration of existing health conditions or delay early intervention, resulting in poorer outcomes<sup>44</sup>.

Poor nutritional status, including both under- and over-nutrition can also lead to health problems, or exacerbate chronic diseases such as high cholesterol or diabetes. Research by O'Reilly<sup>45</sup> reported that around 350 people access the Asylum Seeker Resource Centre's (ASRC) food bank in Melbourne every month. 75% of families using the food bank must rely on this volunteer-run initiative as their primary source of nutritional intake because they have no income. Even with this generous source, many asylum seekers are food insecure and unable to meet the standard nutritional requirements, which has implications for their health<sup>45</sup>.

Lack of income impacting on sufficient nutrition was also highlighted in Scull's<sup>22</sup> study of community based asylum seekers in Queensland by two participants, both of whom have been diagnosed with diabetes since being in Australia. Both have to manage their illness through diet, yet were finding it difficult with only \$50 a week to live on as highlighted in the quote below.

### CASE EXAMPLE /QUOTE

*"That's the problem, I saw just a couple of months ago a dietician, but I have \$50, so I can't, especially I thought you know only expensive is meat, but even vegetables are very expensive." and "As I said, financially it's very very difficult, even eating properly is difficult. I always get sick you know, because there's not enough nutrition. I see a doctor often, but they don't do anything for me, because it's not a disease, but a lack of nutrition." <sup>22</sup>*

## Racism, discrimination and culture

**Racism occurs when the belief that a person's racial background is seen to define their human character or ability and when some races are viewed as superior to others, resulting in discrimination and prejudice. These beliefs deny a person the right to be known and accepted for their own individual characteristics, beliefs and contributions.**

Asylum seekers in Australia encounter discrimination arising from their differences from the wider community, language, dress, skin colour, religious or cultural practices. In addition, the way in which the wider society perceives the legitimacy of their reasons for either arriving in Australia or the way they arrived in Australia (or both) further impacts on how they are viewed.

A range of myths about asylum seekers exists in this country and is perpetuated by both the media and Government forums<sup>46</sup>. These perceptions become particularly problematic when they are seen to challenge the cultural values of the Australian society, which then provokes responses based on fear rather than personal experience. Indeed, the Australian government response to asylum seekers has been described as highly discriminatory reflecting a sense of insecurity and a fear of the 'other'<sup>47</sup>.

A common fear in relation to people who enter Australia seeking asylum via boat or 'unannounced boat people' is that they are violating our sovereignty and that we need to defend our borders and not be "too soft" on this threat to our way of life<sup>48</sup>. In addition, many see asylum seekers who arrive via boat as 'queue jumpers' because they did not enter the country after offshore processing. It has been suggested that this perception is fed in the media with a view that 'queue jumpers' are not the same as 'grateful refugees'<sup>49</sup>. In a survey of 585 people in Australia 'queue-jumping' emerged as the most basic annoyance to participants, which the authors suggest confronts 'traditional Australian values' that you don't 'push in' or 'sneak in'<sup>46,50</sup>.

The important facts here are:

- It is *not* illegal to enter Australia seeking asylum (see section 4)
- *No* boat arrival who could have been a potential threat to national security has ever gained entry into Australia<sup>51</sup>
- The vast majority of asylum seekers arriving in Australia by boat *are* granted protection (thus being 'legitimate' asylum seekers, see section 5)
- More asylum seekers who arrive by boat have been recognised as refugees than those who have entered Australia by air (see section 5)
- In 2011, Australia was ranked 46th (21,805 refugees) as a refugee host country with countries like Pakistan (1.9 million), Iran (>1 million) and Syria (>1 million) in the top three<sup>52</sup>
- Compared to 44 industrialised nations, Australia received only 3% of all asylum seekers applications in 2011 (ranked 13th), or 0.5 per 1000 inhabitants (ranked 18th) or 0.3 per 1 USD/GDP per capita (ranked 14th)<sup>52</sup>
- In terms of permanently resettling refugees under the auspices of the United Nations High Commissioner for Refugees (UNHCR), Australia was ranked third in 2011 (5,597 refugees resettled), with only the United States (43,215) and Canada (6,827) resettling more refugees (not including those resettled under family reunion and other migration programmes)<sup>53</sup>

The issue of racism and discrimination is important to this discussion because the way asylum seekers are presented in the media and discussed in public forums compounds their experience of social exclusion. Colic-Peisker suggests that the way asylum seekers are misrepresented as 'illegals' and 'queue jumpers' is, in fact, dehumanising<sup>25</sup>. Grove and Zwi further claim that asylum seekers are positioned and treated as "*separate, distant and disconnected from the host communities in receiving countries*"<sup>54(p.1933)</sup>. Racism and discrimination, according to Taylor, reduces access to care and the attitudes of the wider community play an important role in settlement<sup>14</sup>.

## CASE EXAMPLE /QUOTE

*Asylum seekers carry sorrow and distress and depend on human sympathy. An asylum seeker is a kneeling person; kneeling in front of the captain of the ship to ask for a reduced escape price; kneeling in front of the aid agency asking to be saved. They get on a boat, on a piece of wood, not knowing where its taking them; their safety and security limited to that piece of wood, risking starving or drowning at sea. We hear politicians saying things like, "Australia is accepting a large number of refugees for an industrialised country". Those numbers consign people to the status of simple statistics. You can forget that people, whether they are asylum seekers or not, are mothers, fathers, wives, husbands, grandparents, daughters and sons<sup>55</sup>.*

## Early life factors and genetics

**Early life experiences of nutrition, health care, education, socioeconomic status and safety have all been shown to have an impact on health and mortality in later life<sup>56</sup>.**

While genetics is not in the scope of this paper, early life experiences prior to migration forms an important determination of health for asylum seekers. Prior to arriving in Australia, most asylum seekers will already have psychological, physical and social symptoms from the traumatic events they have experienced including witnessing the death of family and friends and separating from loved ones (see section 2). It would also not be uncommon for asylum seekers to have had little or no health care access, in their country of origin<sup>57</sup> and to experience human rights abuses at the hands of government authorities<sup>58</sup>.

In addition, poor economic and health care supports in their previous countries mean that many asylum seekers have chronic illnesses; experience nutritional deficiencies; infectious diseases and poor oral health (see section 2). This situation means that many asylum seekers arrive in Australia with poor mental and physical health, and have limited levels of trust of health care providers (see section 2). For children who have experienced detention and are awaiting decisions about their family's refugee status, it is clear that long term effects can be great. The impact of immigration detention on children can be both physical and psychological, and can delay or otherwise negatively impact on ongoing development<sup>59</sup>.

## CASE EXAMPLE /QUOTE

*CD and EF, and their three children aged 8, 5 and 2 years, are refugees from a camp in Tanzania where they have lived for the past 3 years since fleeing civil war in their native country of Burundi. The children have all had recurrent episodes of fever treated as malaria in the camp. The younger two children are malnourished. No immunisation records are available. Pre-departure screening was limited to chest X-ray for those over 11 years, HIV tests for those over 15 years, and hepatitis B and syphilis serology for pregnant women<sup>60</sup>.*

## Individual behaviours and lifestyle factors

**'Lifestyle factors include the aspects of health related behaviours and conditions which entail an element of personal action at the individual level ... strongly associated with the possibility of individual choice'<sup>61</sup>(p.675).**

There is very little information available on the demographics or standard of living for this population<sup>21,44,62</sup> and thus it is difficult to describe the lifestyle factors of current asylum seekers.

Indeed, the notion of personal action towards health related behaviours is more easily discussed in relation to *barriers* for asylum seekers than individual actions towards a healthy lifestyle. Aside from the limitations on resources including healthy food and medications, housing and support noted previously, the period waiting for processing refugee status is one of extreme financial, social and psychological distress that is not conducive to the development of a healthy way of life. In addition, many will have had little access to health care in their own countries and lack knowledge of the Australian health system<sup>17,63,64</sup>. While such barriers prevent self-referral and preventative health seeking practices, they can also prevent individuals seeking care when more serious health issues arise.

The length of time waiting in uncertainty places this group in a vulnerable state where they are unable to plan for the future<sup>18</sup>. The limited access to health care, support and advice for asylum seekers impacts negatively on health and wellbeing. In addition, many live with the fear of family remaining in their country of origin under ongoing potential threat<sup>18</sup>. The existence of symptoms of PTSD including intrusive fears arising from both trauma exposure and ongoing worry for loved ones, and symptoms of depression and anxiety further exacerbate this stressful existence<sup>17,60</sup>.

## CASE EXAMPLE

*A woman in her early thirties arrives in Australia with her three children. Initially, they are supported by ASAS run by the Red Cross. They are able to access health care, and the woman is treated for severe asthma and placed on medication. When the RRT rejects her application, the health care and the support provided by ASAS ends. She finds help from a small charitable organisation, which provides housing and \$400 a month to cover their living expenses. During this time, she is badly injured in a car accident. After leaving hospital, she suffers from ongoing neck and back pain and severe migraines. She is forced to stay in bed for long periods. Her two young teenage girls take on major responsibilities including caring for their younger brother, running the household, and looking after their mother when she is sick. She is lucky to find a doctor who looks after her for free, but she struggles to access specialist services and cover the cost of the medicine she needs. As she becomes more fragile, the physical and emotional stress of her situation takes its toll: she loses most of the hair on her body and becomes almost entirely bald. A specialist tells her it is a common symptom of severe stress and anxiety. Her son starts to express his own distress with disturbing behaviour at school and a mental health professional is called in to assist this young boy<sup>65</sup>.*

## Access to health care

**Access to services is a complex concept and at least four aspects require evaluation. If services are available and there is an adequate supply of services, then the opportunity to obtain health care exists, and a population may 'have access' to services. The extent to which a population 'gains access' however, also depends on financial, organisational and social or cultural barriers that limit the utilisation of services<sup>66</sup>.**

In 2005 a breakthrough for asylum seekers occurred when the Victorian government directed its public hospitals to provide health care free of charge to asylum seekers regardless of Medicare status, which was followed by some other states. In addition, in some states there is some restricted access to dental care, and ambulance services (see section 3).

Yet, access to health care for this population remains problematic. Some Australian states and territories have not taken a formal policy change to care for those who are Medicare ineligible and while primary care is provided by many professionals on a pro-bono basis, there remains a clear lack of access to medication, pathology tests, other investigations and outpatient allied health services<sup>17</sup>. Barriers to accessing health care are substantial and will be discussed separately in section 2 and 3 of this report.

## CASE EXAMPLE /QUOTE

*A 6 year old asylum seeker from South America sustained a fractured humerus following a fall from a bicycle. His family took him to a hospital emergency department where he was X rayed and his arm put in a sling. After follow up with orthopaedics, his family were issued with a bill for \$1400. The hospital debt collectors pursued the family by mail and phone, although it was clear the family could not pay. Subsequently the family was afraid to go to hospital when the boy's grandmother had a fall and sustained a fractured wrist. They were very worried about the impact of their debt on their application for residency with the immigration department<sup>60</sup>.*

## Consequences of social determinants of health for asylum seekers

Considering the status of asylum seekers in relation to the social determinants of health and social exclusion presents an image of deficiency and need. *Pre*-migration needs for health care, mental health support, shelter, safety and education remain lacking for many asylum seekers in Australia *post*-migration. In addition, the restrictions placed on some groups once they arrive in this country and while they wait for a decision about their future, maintains and for many, exacerbates these areas of need.

The framework used in this section highlights the *interrelationships* between the determinants of health, for example: a lack of sufficient income and restrictions around, or difficulty finding work increases social isolation, reduces access to health care, transport, housing and health lifestyle. Similarly, a lack of education, availability of translators, *pre*-migration trauma and finance also impacts on the accessibility to health care. Most asylum seekers arrive in Australia with great need and are often met with systems that are simply not adequate to meet these needs. Although there are many examples of community organisations in this country that, driven by compassion and social justice, provide impressive levels of support for asylum seekers, they are restricted by inadequate Government support.

Cannon's social determinants of health<sup>13</sup> in relation to asylum seekers are presented in Table 3, illustrating that this population experiences deprivation and inequality in relation to each factor. Further, the ability of asylum seekers to access services (especially health care services) and undertake healthy individual behaviours and lifestyles are limited by the deprivations of the other factors in this model.

**Table 3: Summary of the social determinants of health\* in relation to asylum seekers**

SOCIAL DETERMINANTS OF HEALTH IN RELATION TO ASYLUM SEEKERS	
1. Income and social status	Limited ability to earn an income. Dependence on others. Limited support.
2. Social participation	Racism, discrimination, difficulty accessing education, lack of English, and poverty, are all barriers to social participation
3. Education	Low levels of education, literacy and English, restricted access to English classes or other vocation.
4. Health literacy	Limited support and advice, limited English skills and restricted access to English classes, limited access to interpreters.
5. Healthy living conditions	Limited access to employment and/or financial support, housing, resettlement assistance, support and advice, English classes, appropriate nutrition and health care. Living in a state of uncertainty, dependence on charitable organizations, High stress levels and mental health issues.



## SOCIAL DETERMINANTS OF HEALTH IN RELATION TO ASYLUM SEEKERS

6. Racism, discrimination and culture	Dehumanisation based on lack of citizenship, lack of statistics, lack of rights and support. Myths portrayed in the media and in the community add to a sense of isolation. Fears around 'invasion' of others and differences of cultures increase the stress for this population
7. Early life factors and genetics	Pre-migration experiences of deprivation, torture and trauma mean that many asylum seekers arrive in Australia with mental health issues, physical problems and extreme stress resulting in poor sleep, concentration, trust in others and fear.
8. Individual behaviours and lifestyle factors	Positive health related behaviours are restricted by living in a state of uncertainty, limited access to employment and/or financial support, housing, Medicare, resettlement assistance, support and advice, English classes, and appropriate nutrition.
9. Access to health care	Low levels of education, literacy and English, restricted access to English classes, limited support and advice, limited access to interpreters, different cultural understanding of health and health services, fear and mistrust of authority and service providers, inadequately prepared workforce.

\* (Cannon;<sup>13</sup>)

These factors of deprivation impact on asylum seekers lives in relation to *environment* (lack of healthy lifestyle, living in sub-optimal conditions and social exclusion), *health* (increased distress, compounded pre-existing mental and physical health problems) and *support* (increased need for supports, reduced access to services, and lack of services). The consequences of these limitations form a cycle of despair where the need for supports is high, unmet and complicated by barriers of language; trauma and poverty. While asylum seekers arrive in Australia with a range of factors that impact on their health and wellbeing, the almost universal distress and social exclusion they experience is a direct result of limited support services, practical resources and healthy living conditions compounded by discrimination and uncertainty.

Linking all of the health related concerns for asylum seekers is the central aspect of mental illness which is exacerbated by and further exacerbates the despair experienced by this group. In addition, social exclusion – also experienced by many asylum seekers - is both a cause and a consequence of mental illness<sup>67</sup>. Studies measuring the prevalence of major mental disorders in asylum seekers living in the community demonstrate levels of major depression, anxiety disorders and post-traumatic stress disorder much higher than in the general community (see section 2).

Although the use of community detention has increased in recent years, children and families with no visa status are usually subject to periods of immigration detention before being released into the community. A consequence of these conditions is the enduring harm inflicted upon asylum seekers (both children and adults), in particular those detained for prolonged periods<sup>68</sup>.

As discussed in section 3, current mainstream health services have minimal knowledge or understanding of asylum seeker mental health problems. Given the way that mental illness limits a person's ability to access services that may improve their physical, psychological and/or social situation<sup>69</sup>, the assessment of mental health needs should be considered a priority and be addressed alongside settlement issues. Health professionals need to consider holistic approaches to addressing the mental health needs of asylum seekers that incorporate the social determinants of health.

Mental health expertise is also important in supporting and enabling access to appropriate legal services. While the way an asylum seeker tells their story is central to their success in achieving refugee status, loss of concentration, fear, shame and post traumatic disorder offer many barriers to this process<sup>70,71</sup>.

# Conclusion

Many asylum seekers in Australia experience physical and mental health issues requiring support. The causes of these issues are complex and in many cases are socially determined, requiring equally complex responses. Any service offering health and wellbeing support to asylum seekers must take into account their specific need for interpreters, mental health specialists and the complex legal issues they may be embroiled in. In addition, the limitations of their low income and social status means that a range of services are required to support this population and a sense of creativity and determination to help meet their needs with such complex limitations.



## Section 2:

# Literature review: health of asylum seekers in Australia



## Summary section 2

There is a lack of research in the field of asylum seeker health due to a range of challenges involved in conducting high quality studies. The available literature focuses mainly on asylum seekers in detention and although policy has changed in this area, the findings of these studies are vital to understanding long term outcomes and the needs of asylum seekers in the community.

Asylum seekers in immigration detention centres have significant psychological morbidity which is directly associated with the length of time spent detained. As well as depression, PTSD, anxiety and some psychotic illnesses, there are high rates of self-harming and suicidal ideation reported. Although Australian policy has been changed to discontinue the detention of children and their families, it is still alarming to consider that children suffered psychological distress including emotional and behavioural disorders, language and developmental delays. It is unclear to what degree these problems affect children long-term.

Among community-residing asylum seekers, psychological problems are among the most common reasons for presentation to a community-based medical practice. Asylum seekers presenting to specialist mental health services have high rates of PTSD, depressive disorders, anxiety and panic disorders. Psychological symptoms can be pervasive and affect the wellbeing of asylum seekers for many years.

There are several post-migration factors that cause, or exacerbate stress and mental illness among asylum seekers. Fear of repatriation and indeterminate visa status also appear to significantly contribute additional stress for asylum seekers awaiting their immigration decision both in the community and in detention. Other stressful factors include financial, housing and employment instability; poor access to services; concern for family back home; social isolation; and the immigration process.

In addition to significant mental health issues, the physical health of asylum seekers can also be challenging for health practitioners to manage, both in immigration detention and the community. Infectious diseases may be higher among asylum seekers than the general population due to poor living conditions and inadequate access to health care prior to coming to Australia. Other problems include nutritional disorders, inadequate immunisation status and dental problems. Chronic diseases are also common, but may remain undiagnosed and untreated.

Asylum seekers face many barriers in accessing health services in the community. Visa status affects an asylum seekers' right to Medicare, work rights or income support. Inadequate income may result in refusal from a service or an individual ceasing treatment. Stretched resources, reliance on volunteers, a lack of information, restrictive access criteria, poorly developed referral pathways and difficulties navigating the health system can prevent asylum seekers from accessing essential services. Quality of care may be compromised by health workers' poor knowledge of asylum seeker health, language barriers, the absence of an accurate medical history, and inadequate use of interpreters. When working with asylum seekers, health professionals often need to act as patient advocates, and provide services in constrained environments. The enormity of their responsibility requires support from others in the profession to lobby for the welfare of asylum seekers, but equally, to ensure that health professionals' wellbeing is considered.

# Introduction

A review of Australian peer-reviewed publications was conducted in June 2012. The purpose of this literature review was to examine information about the health of asylum seekers in Australia, with particular attention to Medicare-ineligible asylum seekers residing in the community. Due to the lack of data and discussion around this particular group in academic forums, the review was widened to consider the general and mental health status of asylum seekers in immigration detention and those in the community either with or without Medicare. The methodology of the literature review has been attached as an appendix. The following discussion explores the mental and physical health status of asylum seekers in detention and those in the community. Particular attention is paid to factors which influence mental health outcomes, namely: the impact of prolonged detention on the mental health of adults and children; indeterminate visa status and the fear of forced removal. In addition, some of the barriers identified as affecting community residing-asylum seekers' access to health services will be discussed, as these factors are tied into the limitations of service provision discussed in section 3. It is important to remember that asylum seeker policy changes rapidly. The discussion and opinions of authors reflects the policy climate at the time the article was written, and may not necessarily be an accurate representation of the situation today.

## Research limitations: Brief discussion

Few studies have been published on the health needs of asylum seekers<sup>72,73</sup>. There are several practical and ethical reasons why conducting research with this particular population group can be challenging. Due to their indeterminate visa status and lack of social standing, asylum seekers in the community are often 'hidden' from society - they are not recorded in the electoral role, on census data or official registries<sup>74</sup>. Fear of deportation and lack of stable accommodation may lead them to a transient existence and make it difficult for researchers to make contact with them and engage them in projects<sup>74</sup>. Language barriers, working with interpreters and the need to validate questionnaires or interview guides for linguistic and cultural appropriateness add further challenges, while also undermining the results due to potential bias. It is reported that some asylum seekers are mistrusting of written documentation such as consent forms and may be fearful of providing personal information<sup>17</sup>.

Ethically, there are concerns that contributing to research might re-traumatise and exacerbate anxiety in asylum seekers as they recount their pre and post-migration struggles<sup>74</sup>. Silove et al. highlight the importance of the research group being actively involved with the asylum seeker population prior to commencing research, in order to reduce the risk of being intrusive and to ensure the population group benefit from the process<sup>74</sup>. Researchers need to be mindful of issues around informed consent due to language barriers and unfamiliarity with research procedure.

There have been ongoing problems accessing asylum seekers in detention for the purpose of research, resulting in very limited data. Despite appeals from academic and medical experts with compelling reasons to conduct systematic health surveys in immigration detention centres, access has been denied by the immigration department<sup>75</sup>. As stated by Steel et al.<sup>76(p.530)</sup>: "previous attempts to engage the department on issues of research in detention centres had been met with delays and inconclusive outcomes."

As well as systemic barriers preventing researchers from gathering health outcomes on detainees, data on asylum seekers living in the community have been equally difficult to access. There is a lack of reliable data on the number of asylum seekers in the community and the number without work rights or Medicare. This has been raised as a point of conflict between population health researchers and government who can be reluctant to provide such figures<sup>77</sup>. Despite researchers insisting on the provision of accurate government statistics for meaningful analysis, this remains an ongoing problem.

The empirical research that *is* available should be interpreted with some caution due to the nature of research in this area involving case studies and small sample sizes (as a result of the previously identified issues). After conducting a systematic literature review on the mental health impact of immigration detention, Robjant et al.<sup>78</sup> concluded that the available literature is not necessarily representative of the immigration detention population due to methodology. Many studies also rely on retrospective measures, which may lead to recall bias<sup>78</sup>. Often the recruitment technique, researchers' familiarity with a community group and need for interpreters means that a research study is limited to a particular ethnic group. The results of a study of one ethnic group may not necessarily be transferrable to people from a different background.

Although these issues have impacted the volume and depth of research that has been conducted with asylum seekers, there still remains a rich source of information that can be drawn upon to inform health professionals, advocates and policy-makers concerned about the welfare of this vulnerable population group. The following discussion is a summary of the available evidence that was identified through a thorough review of the Australian literature.

## Pre-migration factors and the health of asylum seekers

The health – both physical and mental – of asylum seekers arriving in Australia by boat or plane is likely to have been adversely affected by experiences in their country of origin, refugee camps, transit countries and the journeys between these destinations. Asylum seekers are people who are applying for protection due to fear of persecution in their home country. As a result, many have been exposed or suffered direct pre-migration trauma including: torture; physical, sexual or psychological abuse; imprisonment for political reasons, the murder of, or separation from family and friends<sup>60,74,79</sup>. The tragedies endured by many asylum seekers prior to coming to Australia, will have a lasting impact on their psychological and physical wellbeing. This is most pertinent for people who have been tortured, which is the strongest factor contributing to PTSD<sup>80</sup>.

In addition to these horrendous, terrifying experiences, some asylum seekers will have been situated in refugee camps where they might be subject to overcrowding, poor nutrition, conflict and violence, poor hygiene, the spread of infectious diseases and inadequate medical care<sup>60</sup>. Economic disadvantage and lack of access to trained doctors exacerbates the risk of both infectious and chronic illnesses that may be underlying and progress undetected and untreated. The conditions during travel to Australia by boat may have been hazardous and asylum seekers may have suffered ongoing abuse in transit<sup>60</sup>. These conditions are likely to contribute to the types of medical conditions encountered by health practitioners when they assess recently-arrived asylum seekers<sup>72</sup>.

## Asylum seekers in immigration detention

As explained in greater detail in section 5, asylum seekers arriving in Australia without authorisation (usually by boat), may be subject to immigration detention. A large proportion of the peer-reviewed literature concerning asylum seekers focuses on the detrimental impact of mandatory detention on mental health. This scoping study is not primarily concerned with this group, as their health care is the responsibility of the Australian government. However, it is important to explore the health status of asylum seekers in immigration detention and the effect of detention on mental health because at present, a large number of asylum seekers are being released into community with bridging visas. Health service providers need to be mindful of this experience and respond with appropriate care and support. Research conducted by Hotham Mission Asylum Seeker Project reported asylum seekers in the community who had been in an immigration detention centre were three times more likely to seek medical attention, particularly for mental health issues, than those who had

never been in detention<sup>64</sup>. In order to better understand the health profiles and needs of asylum seekers residing in the community, the following section discusses the available literature on immigration detention, with a particular focus on mental health.

## Immigration detention and mental health

As discussed in section 5, Australia's immigration detention programs vary in nature. Some facilities are located in remote, isolated areas with high security and limited access to recreational activities; while others are more domestic, have lower security and detainees can make supervised visits to community facilities. There is wide consensus that time spent in detention directly affects the mental health of individuals. Although no health surveys with random sampling have been conducted in immigration detention centres, there have been a few key studies that offer some insight into the types and prevalence of mental illness among detained asylum seekers. Overall, the literature consistently demonstrated high rates of depression, anxiety, PTSD, self-harming and suicidal ideation as well as psychosis in asylum seekers who have been detained. The international literature supports the findings from Australian data<sup>78</sup>. Some of the key studies conducted in Australia are discussed in further detail here.

Adverse psychological impact from detention is likely to be derived from the deprivation of liberty, the ongoing uncertainty regarding repatriation, social isolation and the environment of the detention centre; including potential exposure to forced isolation, riots, hunger strikes, racial abuse and self-harming, among other disturbing events<sup>81-83</sup>. Results of qualitative and quantitative studies on previous detention experiences showed that the asylum seekers had found the detention environment to be punitive and dehumanising, characterised by deprivation and confinement<sup>81</sup>. In addition, Sultan describes "boredom, aimlessness and apathy", difficulties for asylum seekers in accessing interpreters and at times having to negotiate with correctional staff to see a medical practitioner, as other factors which contribute to poor mental health outcomes in detention<sup>83</sup>.

To determine the health status of asylum seekers in immigration detention, the study by Green et al. involved reviewing the electronic records of over 700 detainees<sup>84</sup>. They selected a sample by stratifying for those who had been in detention for over 3 months in order to review the effect of time in detention on health status. Of the proportion of 'new conditions' - those documented in the medical record for the first time - 9.2% of these were psychological conditions. Detainees who had been in the detention centre for more than 12 months commonly reported mental health and social problems. Although mental health was a concern for all groups in detention, the rates of new mental illness were 3.6 times higher in people who had been detained for over 24 months compared to those who were released within three months. Overall, the reason for, and time spent in detention was associated with poorer health outcomes, most notably for mental health. It is important to note that during the audit period (2005-06), fewer asylum seekers were coming to Australia by boat and so the detention population discussed differs to those found in immigration detention centres today. It is likely that the rates of mental illness would be much higher than reported in this study as asylum seekers arriving by boat are likely to have endured torture and trauma and are therefore at higher risk for mental illness.

## Families in detention

Although immense efforts have been made over the last few years to move all families and unaccompanied minors into alternative detention programs, some of the landmark studies conducted in the past concerned families and provide integral insight into the prevalence of mental health disorders among detainees. Steel et al.<sup>76</sup> conducted interviews by phone with ten asylum seeker families in prolonged detention in order to determine the degree of psychological suffering experienced by detainees. The researchers found that nearly all children and adults reported extreme distress associated with fear of being sent home. Some reported being physically assaulted by detention officers or being separated from their family, including children from their parents. Self-harm, attempted suicide and hunger strikes were common, with nearly all people interviewed having witnessed such events. All children complained of boredom and social isolation. Such factors are highly likely to have contributed to the high prevalence of depression, post-traumatic stress

disorder (PTSD), separation anxiety disorder, suicidal ideation and self-harm among detainees. Assessment by psychologists revealed that all asylum seeker adults interviewed suffered from major depressive disorder and most (86%) met the criteria for PTSD. Suicidal ideation was experienced by nearly all adults (93%) and a third had tried self-harming. Psychiatric conditions in children were equally alarming with all cases receiving a diagnosis of at least one psychiatric condition and 80% having multiple disorders.

In the study by Mares et al., children and their families were referred from an immigration detention centre to the Child and Adolescent Mental Health Service (CAMHS) for assessment and treatment<sup>85</sup>. All of the children referred had at least one parent affected by mental illness: 87% of adults had major depression; 56% had PTSD; 25% had psychotic illness requiring hospitalisation and 31% had tried self-harming. Among even the youngest children, emotional and behavioural disorders were common and many had language and developmental delays. All of the children had witnessed graphic, disturbing events such as attempted suicides and self-harm, causing additional concern for their parents' wellbeing. All children in the group aged 6-17 years were pre-occupied with death and met the criteria for major depression with suicidal ideation and PTSD. Anxiety disorders were common and some persistent somatic symptoms were present in some. The high levels of psychopathology in this sample referred for assessment by CAMHS is similar to that reported in Steel et al.<sup>76</sup>. Procter<sup>86</sup> draws attention to the effect that mental distress can have on children's neurological development and functioning as well as increased risk of mental illness and suicide in later life. The relationship between parents and children is strained in such facilities and limits parental capacity<sup>85</sup>. Additionally, parental wellbeing and degree of traumatisation affects the vulnerability of children to emotional and behavioural disorders, including post-traumatic symptoms<sup>85</sup>.

An 'insider's perspective' of immigration detention written by a medical practitioner who fled Iraq and was subsequently detained, gives a personal account of life inside the centre<sup>83</sup>. Sultan describes the mental state of detainees as deteriorating in stages, depending on the length of time spent in detention and their application outcomes. Psychological disturbance among children is common and can include: "*separation anxiety, disruptive conduct, nocturnal enuresis, sleep disturbances, nightmares and night terrors, sleepwalking, and impaired cognitive development. At the most severe end of the spectrum, a number of children have displayed profound symptoms of psychological distress, including mutism, stereotypic behaviours, and refusal to eat or drink.*"<sup>83(p.595)</sup> Development of psychological disorder appears to be associated with the mental state of the parent. Sultan conducted semi-structured interviews and recorded the findings of 33 detainees who had been in detention for more than 9 months. All but one participant displayed symptoms of psychological distress, with 85% expressing chronic depressive symptoms and over two-thirds reporting suicidal ideation. A few (7) were observed to have signs of psychosis but had not yet received appropriate care<sup>83</sup>.

Although pre-migration trauma is highly likely to be a primary source of distress, it is argued that the experience of immigration detention is an *independent* risk factor for psychological outcomes. The landmark study conducted by Steel et al.<sup>76</sup> revealed the rate of psychiatric illness in both children and adults was substantially higher than that found in refugee populations who have not been in detention. For adults there was a three-fold increase in psychiatric disorders, and for children a 10-fold increase, since being detained. They also had a higher dependence on medication and greater need for case-worker support<sup>76</sup>. A systematic review of the international literature on the mental health impact of immigration detention concurred that worse outcomes are associated with longer periods of time in detention<sup>78</sup>.

## Current context

The conditions of detention centres have been the subject of a number of independent inquiries. These have included inquiries by parliamentary committees; investigative bodies like the Human Rights and Equal Opportunity Commission (HREOC); government-commissioned such as the Flood Report and Palmer Inquiry and international bodies such as the United Nations High Commissioner for Refugees (UNHRC). It is important to note that following these inquiries, operational and policy changes were instigated to improve conditions in detention centres: a health advisory group has been established and a set of guidelines on minimal standards of health care in detention centres has been published<sup>87</sup>. As a result, the conditions of immigration



detention centres have improved, although there remain ongoing concerns, particularly in relation to the recommendations in the Report of the Expert Panel on Asylum Seekers<sup>88</sup>, including offshore processing and undefined time limits for people awaiting their visa outcome. These issues will be discussed in greater detail in section 5. The way these policies are enacted will inevitably affect mental health outcomes for asylum seekers, both now and into the future.

## Immigration detention and physical health

Asylum seekers in immigration detention centres are likely to have complex medical profiles, including both infectious and chronic diseases, similar to recently arrived refugees in the community. However, an additional challenge is presented in detention as asylum seekers have not undertaken pre-arrival screening, have no medical history and access to health services is not as readily accessible and comprehensive as in the community. In addition, a number of physical health conditions may be unique to the detention environment or a result of the journey to Australia by boat, such as injuries or dehydration<sup>89</sup>.

People arriving in Australian territory by boat without a valid visa are required to have a health screen upon arrival at a detention centre. There is a specific protocol for the health screen, the primary aim of which is to ensure that unauthorised boat arrivals receive treatment for any diseases of public health significance<sup>87</sup>. One study by King and Vodicka reported the results of 7000 documented screenings of recently arrived asylum seekers in immigration detention centres. Rates of infectious disease were higher than the general Australian population for tuberculosis, malaria, hepatitis and some infectious skin conditions<sup>90</sup>.

In addition to general health issues identified on arrival, asylum seekers may develop new health problems during the time spent in detention. Skin diseases such as eczema, fungal infections and impetigo may result from the stress and living conditions of the detention centres, while injuries may be accidental, or related to self-harming<sup>89</sup>. As discussed earlier, the study by Green et al. involved reviewing the electronic records of over 700 detainees<sup>84</sup>. The results showed that on average, detainees had 1.2 health encounters per week (this included new presentations, follow up from previous presentations and routine screening and assessment). New health problems were more commonly encountered in asylum seekers who had arrived by boat, rather than by air. The most common complaints were for dental and respiratory conditions and lacerations. Asylum seekers who had been in the detention centre for more than 12 months commonly reported musculoskeletal conditions. Respiratory, ear and skin infections were frequently reported as were injuries, some of which (6.2% of cases) were due to self-harm<sup>84</sup>. As stated already, it is important to remember that the immigration detention population has changed dramatically since this audit was conducted. Although there are fewer women detained than men, gynaecological and maternal health, including pregnancy monitoring, may also be necessary in immigration detention<sup>89</sup>.

## Access to health services in immigration detention

Currently, health services in immigration detention centres are provided by a government contracted company called International Health and Medical Services (IHMS). Asylum seekers are able to access mental health and medical services as clinically required, and there are mechanisms in place to formally monitor detainees' mental health status at regular intervals. Some new guidelines and protocols have been put in place to better manage mental health needs but literature suggests that there have been problems in the past for asylum seekers accessing services while in detention. The research conducted by Steel et al.<sup>76</sup> found poor access to emergency medical care, long-term care, dentistry and counselling services were common complaints of the families interviewed. The participants in the study by Mares et al. also reported a lack of access to trained counsellors<sup>85</sup>. The authors were concerned about the inability to implement the interventions required to improve mental well-being, including the immediate removal of highly vulnerable detainees into the community. All of the participants reflecting on their previous experience in detention in the study by Coffey et al. reported experiencing frustration due to the lack of health care available to them and delays in accessing assessments and medications. In addition, some even expressed distrust towards the health care professionals who worked there<sup>81</sup>.

# Community-residing asylum seekers

Asylum seekers residing in the community, traditionally are those who arrived by plane with a valid visa before applying for protection onshore. Since November 2011, thousands of asylum seekers have been released from immigration detention with bridging visas, to allow them to remain lawful in the community until they receive an outcome on their visa application. In addition, asylum seekers in community detention arrangements access health services in the community, with facilitation of IHMS. These three broad groups make up the majority of asylum seekers in the community (there are also those on a 'negative pathway' and unlawful people; see section 5). Each group, and importantly, each individual, have unique health needs. Unfortunately, little research has been conducted on these groups due to the limitations described at the start of this section. The research that is available was conducted prior to the November 2011 policy changes and so primarily centres around those who arrived by plane. It does not distinguish between asylum seekers with and without Medicare or access to other support services and so may not be generalisable to the whole asylum seeker population. Regardless, the literature that is available is key to understanding the needs of asylum seekers living in the community.

## Mental health status of community-residing asylum seekers

The mental health status of asylum seekers living in the community is dependent on a number of factors. Like those who arrive by boat, asylum seekers arriving by plane may have suffered torture and trauma and face immense challenges upon arrival in Australia. Unlike boat arrivals, who when released from detention receive some orientation and support, albeit limited, asylum seekers arriving by plane have virtually no formal settlement assistance and face many challenges navigating the unfamiliar legal, employment, housing and health systems. It is likely that other resettlement challenges include navigating the complex visa process, adapting to a new country and unfamiliar culture<sup>91</sup>, while difficulty accessing English language classes can compound social isolation and hinder employment opportunities for those trying to make a new life for themselves<sup>92</sup>. Procter highlights the immigration process as a source of mental distress and trauma, as asylum seekers are required to retell and be judged by their story, perhaps having their credibility denied<sup>92</sup>.

There are a number of post-migration factors that can increase the risk of, or directly contribute to stress and poor mental health outcomes among asylum seekers in the community. Some of the factors include<sup>17,64,93</sup>:

- financial instability
- housing insecurity
- inability to work
- difficulties finding work
- difficulty accessing health care
- separation from family
- worries about family back home
- negative experiences with immigration officials
- delays in application processes
- boredom
- social isolation

Many of these factors are due to stringent government policies designed to 'deter' onshore protection visa applicants, yet they only result in exacerbation of an already challenging resettlement period<sup>94</sup>. It is likely that some asylum seekers also feel guilt and shame over having to rely on charities or relatives to support them financially and materially, while they wait for their application to be processed<sup>82</sup>. These social determinants of health are discussed in greater detail in section 1.

## Indeterminate visa status

Qualitative data from semi structured interviews with asylum seekers have consistently reveal that participants were fearful of being repatriated and worried for the safety of their family back home<sup>74,82</sup>. The threat of forced removal from Australia was associated with fear and trauma, resulting in sleep disturbance, intrusive thoughts, loss of motivation, loss of self-esteem and anger<sup>82</sup>. Many found it difficult to make long-term plans for the future and worried for their children. Feelings of powerlessness, rejection and statelessness further exacerbated their mental state<sup>74</sup>, with some reporting their stress was so debilitating they became unwell<sup>95</sup>. Even more concerning are those whose applications are rejected, resulting in repatriation. Self-harming and suicidal behaviour has been known to increase after asylum seekers have been informed of a visa rejection<sup>96</sup>.

Between 1999 and 2008, asylum seekers who arrived in Australia unlawfully by boat were subject to temporary protection visas (TPVs) if found to be a refugee. TPVs were usually granted for three to five years duration and recipients were excluded from a range of government entitlements and were not guaranteed a permanent visa. Although TPVs have now been abolished, the results of research conducted with refugees under this policy provide an important perspective on the effect that indeterminate visa status has on the mental health of asylum seekers with bridging visas in Australian communities. It is likely that in the coming years there will be similarities drawn between TPVs and the 'no advantage' policy implemented by the Australian government. A number of studies conducted in Australia showed that compared to their compatriots with permanent protection visas (PPVs), TPV holders - who were subject to more restrictive welfare policies and faced uncertainty about their future - had poorer mental health outcomes<sup>91,93,97</sup>.

A follow up study with Mandeian refugees over three years found that moving from TPV to PPV status was associated with a significant reduction in PTSD symptoms, depression symptoms, living difficulties and improvements in mental health-related quality of life<sup>91</sup>. A similar study with a two-year follow up of refugees from Afghanistan and Iran demonstrated that despite similar exposure to pre-migration trauma between the two TPV and PPV groups, TPV holders had higher baseline levels of anxiety, depression and overall distress which increased over time<sup>93</sup>. They also experienced greater settlement difficulties and had a poorer acquisition of English language skills, which contributed to social isolation. Uncertainty of visa status was the strongest predictor of mental health outcomes in one population group<sup>97</sup>. Consistently, it has been suggested that insecurity and perceived injustice due to delays in gaining refugee status, as well as limitations on access to welfare and work and service entitlements negatively impacts asylum seekers' ability to integrate successfully into the community resulting in social isolation and poor health outcomes<sup>17,81,98</sup>. This research highlights the importance of security for the mental health and well-being of asylum seekers and refugees post-migration<sup>91</sup>.

## Prevalence of mental health disorders

As discussed in the section on research limitations, limited information is available on the prevalence and types of health problems experienced by asylum seekers residing in the community in Australia. No research presents data specifically on Medicare-ineligible asylum seekers. The best data available are from research conducted by Correa-Velez et al., which involved a retrospective audit of the presentations of asylum seekers attending specialist clinics in Melbourne<sup>21</sup>. The majority of asylum seekers in this sample (88%) were Medicare-ineligible during the retrospective audit period (access to Medicare policy has since improved somewhat). Psychological problems, including general symptoms and complaints, depression, anxiety and sleep disturbance, among others, were among the most common reasons for presentation (see Table 4). The authors state that the prevalence of social and psychological presentations correlates with other research



around mental health problems in asylum seekers<sup>21</sup>. Similarly, according to research conducted by Hotham Mission Asylum Seeker Project, depression, anxiety and stress were some of the most common reasons for seeking medical attention among asylum seekers<sup>19</sup>.

An earlier study involved 33 asylum seekers from East Timor who were attending a mental health service in Sydney<sup>74</sup>. Those involved in the study had experienced high levels of trauma related to witnessing horrific events such as the murder of family members or friends, forced separation from their family, rape, sexual abuse or torture. Nearly all (80%) asylum seekers assessed met the criteria for at least one psychiatric condition: PTSD (73%); major depressive disorder (53%); minor depression (10%); dysthymia (13%); generalised anxiety disorder (37%); and panic disorder (20%) were identified, with many suffering co-morbidities<sup>74</sup>. Another study of war-affected Tamil refugees, immigrants and asylum seekers also yielded high rates of post-traumatic stress disorder, particularly related to having experienced torture<sup>99</sup>.

Of particular concern is evidence that psychological distress and other problems are still common among refugees and asylum seekers who have been living in the Australian community for an extended period of time. One study of refugees and asylum seekers found that despite living in the community for over three years (on average), all participants suffered ongoing difficulties such as insecurity, difficulties with relationships, profound changes to their sense of self and mental health problems<sup>81</sup>. Mental health assessments confirmed that anxiety, poor quality of life, persistent memory and concentration difficulties were apparent, with the majority meeting the criteria for depression and PTSD. Anxiety expressed itself in the form of nightmares and flashbacks from detention, paranoia and constant worry about deportation. The symptoms of mental illness were pervasive and disrupted quality of life, relationships and sense of self-worth. This suggests that the significant trauma suffered pre-migration and during immigration detention, has a long-term impact on mental well-being.

Mental illness can have a profound impact on an individual's quality of life, as well as affecting their family and community in many cases. One other implication has been highlighted by Procter, who argues that post-traumatic stress symptoms can have an effect on an asylum seekers' ability to recount their personal story and explore their refugee claims<sup>86</sup>. This can make their application for a protection visa fraught with difficulty and research shows they are systematically less likely to have their claims accepted<sup>71</sup>.

## Physical health status of community-residing asylum seekers

Depending on the country of origin, the prevalence of and type of medical conditions can vary among asylum seekers residing in the community. A review of international studies on the health issues affecting asylum seekers revealed that common conditions are generally infectious or nutritional in nature and their disease burden differs to the general Australian population<sup>38</sup>. A summary of the types of general health conditions more commonly encountered among asylum seekers than the general population is provided below. A number of comprehensive resources and guidelines have been developed to improve health workers' knowledge of refugee health and should be consulted for further information.

Some infectious diseases that medical personnel may encounter among asylum seekers include: tuberculosis; malaria; HIV; Hepatitis A, B and C<sup>60,72</sup>. Parasitic infections such as intestinal helminthes, hookworm, *ascaris lumbricoides*, *trichuris trichiura*, schistosomiasis, strongyloides, amoebiasis, and giardia are also more common among some asylum seekers<sup>60,72</sup> as well as upper and lower respiratory tract infections<sup>89</sup>. *Helicobacter Pylori* is also frequently reported, particularly among people who have spent time in refugee camps<sup>38</sup>. Physical sequelae of past torture or violent conflict can include musculoskeletal pain and weakness, poorly healed fractures, epilepsy or deafness from head injuries<sup>38</sup>. To assist health practitioners in identifying diseases common among asylum seekers and refugees, guidelines for screening have been developed over the last 25 years in line with epidemiological studies<sup>89</sup>.

Like many Australian-born people, chronic, non-communicable conditions such as heart disease, high blood pressure, type 2 diabetes and other metabolic disorders are also prevalent in the asylum seeker population.

It is likely that these chronic conditions have been inadequately managed prior to coming to Australia or not identified at all, which highlights the importance of preventive screening and early treatment<sup>62,89</sup>. Nutritional disorders, which may be related to intestinal parasites or inadequate nutritional intake, may lead to under-nutrition, vitamin or iron deficiency or delayed growth and developmental problems in children<sup>72,100</sup>. Severe dental disease is common in asylum seekers who may have poor nutritional status, lack of dental hygiene, limited access to dental health checks and even physical trauma<sup>100</sup>.

The only known published data available on physical health problems affected asylum seekers residing in the Australian community come from the study by Correa-Velez et al.<sup>21</sup>. As stated earlier, this study involved a retrospective audit of the presentations of asylum seekers attending three specialist clinics in Melbourne. On average, patients visited the clinic 3.4 times per year. Social problems were a common reason for presentation, including problems with housing, immigration, work, food or finances. The rate of presentation for specific conditions is shown in Table 4. Around 20% of presentations were for four or more different medical and related needs. General check-up rates were low at only 2.6 per 100 encounters, while prescriptions were common reasons for presentation at 16.5 per 100 encounters. Musculoskeletal, digestive and respiratory problems were all common complaints.

The available information on asylum seekers living in the community suggests that they suffer similar problems to that experienced by recently resettled refugees. The complexity of potential health conditions presents a challenge for health workers who are unfamiliar with the screening, assessment and treatment of conditions less commonly encountered in Australia. Ongoing training is essential to maintain knowledge and ensure best practice.

**Table 4: Reasons for encounters with health services of asylum seekers**

[Table sourced from Correa-Velez et al. 2008<sup>21</sup>. See full-text article for more details] 2005-06; n=998

REASONS FOR ENCOUNTER	RATE PER 100 ENCOUNTERS	REASONS FOR ENCOUNTER	RATE PER 100 ENCOUNTERS
<b>General and unspecific</b>	<b>59.9</b>	<b>Digestive</b>	<b>19.0</b>
Prescription	16.5	Abdominal pain, other	3.3
Follow up, unspecified	12.1	Epigastric pain	2.4
Test results	8.5	<b>Female genital</b>	<b>2.6</b>
Allergy	3.3	Menstrual problems	4.2
Check up, general	2.6	<b>Skin</b>	<b>12.2</b>
Health education	2.5	Localised rash	2.3
Weakness or tiredness	2.4	<b>Endocrine, metabolic or nutritional</b>	<b>12.2</b>
<b>Musculoskeletal</b>	<b>27.1</b>	Diabetes, non-gestational	4.5
Back complaint	6.0	<b>Cardiovascular</b>	<b>11.1</b>

REASONS FOR ENCOUNTER	RATE PER 100 ENCOUNTERS	REASONS FOR ENCOUNTER	RATE PER 100 ENCOUNTERS
Injury, musculoskeletal, not specified	3.5	Hypertension	4.2
Knee symptom or complaint	2.8	Cardiovascular check-up	2.4
Foot or toe symptom or complaint	2.7	<b>Social problem</b>	<b>10.7</b>
Shoulder symptom or complaint	2.0	Immigration issue	4.6
<b>Psychological</b>	<b>26.5</b>	Social welfare problem	3.8
Sleep disturbance	6.4	<b>Neurological</b>	<b>9.5</b>
Psychological symptom or complaint	5.8	Headache	5.7
Depression	4.5	Vertigo, dizziness	2.9
Anxiety	3.1	<b>Urological</b>	<b>8.7</b>
<b>Respiratory</b>	<b>21.4</b>	Haematuria	2.2
Cough	5.5	<b>Male genital</b>	<b>4.7</b>
Acute upper respiratory tract infection	4.5	<b>Pregnancy or family planning</b>	<b>4.7</b>
Sneezing or nasal congestion	3.1	Contraception	2.1
Throat symptom or complaint	2.5		
<b>Ear</b>	<b>2.1</b>		
<b>Eye</b>	<b>7.2</b>		
<b>Blood or immune mechanisms</b>	<b>0.9</b>		

# Barriers and facilitators to accessing services in the community

The previous sections have explored the complex general and mental health profiles of asylum seekers, highlighting the need for high quality, appropriate, multidisciplinary and well-integrated services. Even where adequate health services exist, there may be factors which affect access for asylum seekers living in the community. This is regardless of whether they are with or without Medicare access or additional support from welfare organisations. As discussed in section 5, the Victorian and NSW Departments of Health have developed policy frameworks which require public hospitals and some community services to waive fees on an approved set of services for asylum seekers who present without a Medicare card. This has greatly improved equity of access, however the policy is not all-encompassing and simply providing the services free of charge does not necessarily result in the provision of effective care.

The Australian literature frequently points to a number of factors which affect asylum seekers' access to health services. For the most part, these factors are generally inhibitors or 'barriers', and can broadly be categorised into: political barriers; systemic barriers; and sociocultural barriers. The implications of inadequate access to health services can be devastating. Delayed care can result in detrimental health outcomes including preventable hospitalisations<sup>38</sup>.

## Political barriers

Asylum seeker health policy is directly linked with immigration policy, which is frequently changing and thus making health care access confusing and fragmented for both patients and health care workers<sup>73</sup>. Kisely argues that the health of asylum seekers is compromised by a fragmented policy between state and federal governments, under-funded services and restrictions on benefits and services<sup>79</sup>. In particular, lack of access to Medicare and work restrictions places significant financial pressure on individuals, but also increases the service burden on pro-bono health practitioners who are trying to fill the service gaps where fee waiver policies do not exist. This has implications for both the individual, whose vulnerability to poor health exacerbates their problems, but also for the wider community.

As discussed in section 1, financial instability or poverty are significant problems faced by many asylum seekers living in the community. This means that health care costs can be prohibitive, particularly when they don't have access to Medicare or fee-waiver policies don't exist. The need for specialist medical care, dental procedures, pathology and diagnostic investigations, for example, would place an enormous financial burden on some asylum seeker families. A quarter of those surveyed by Hotham Mission Asylum Seeker Project had been refused medical treatment at some point due to being unable to pay, their visa status, or lack of Medicare eligibility<sup>64</sup>. Ongoing costs of medical treatment, including paying for medications and follow up care, can become a significant financial burden and asylum seekers may cease treatment due to high costs<sup>101</sup>. More recent research yielded similar findings with asylum seekers reporting difficulties seeing a private doctor or specialist because they could not afford the fees and many had negative experiences being billed for consultation<sup>17</sup>. In some cases, unpaid bills by asylum seekers have resulted in legal threats, which obviously exacerbate the stress they are already experiencing and greatly reduce the likelihood of seeking out additional health services<sup>101</sup>. Other health care costs that might be out of reach for this group including prescription and over-the-counter medications and out of pocket expenses for items like blood glucose test strips, spectacles and other medical equipment<sup>17,82</sup>.

It is interesting to note that in the study by Correa-Velez et al<sup>21</sup>, the most common specific reason for presentation was prescription medication – involved in nearly one in five presentations - yet, as discussed in section 3, ensuring access to medications is a major challenge.

## Systemic barriers

Systemic barriers can be factors which inhibit asylum seekers' access to health services or reduce the quality of those health services, thus leading to inadequate service provision. In the community, the most obvious problem with services providing for the health needs of asylum seekers is that many specialty clinics are over-stretched and under-resourced, particularly in mental health<sup>102</sup>. This means that there may be long delays, waiting lists, or restrictive criteria, as is the case for some mental health services<sup>64</sup>. Primary care practices with a high number of refugee and asylum seeker attendees may find complex assessments time consuming and therefore overwhelming for the practice<sup>72</sup>. Participants in the study by Spike et al. were concerned that when they were referred to a pro-bono doctor through a charitable service, they often had to wait weeks and were not offered many options<sup>17</sup>. Similarly, those who were supported by the ASAS reported delays in accessing a GP or specialist. The stakeholders interviewed concurred that such delays were sometimes due to challenges negotiating pro-bono services<sup>17</sup>. The same problem was identified by Correa Velez et al.<sup>21</sup>. Referrals to specialist services and pathology were found to be a challenge for the health professionals working in the clinics and they were required to dedicate considerable time to requesting and negotiating free service provision for asylum seekers who could not afford to pay for health care and were ineligible for Medicare<sup>21</sup>.

Another issue that hinders access is a lack of information on eligibility and availability of health services. It can be difficult for asylum seekers trying to navigate the health system and differentiate between public and private services<sup>73</sup>. This may be due to resources that are not in the asylum seekers' language or a lack of case workers to provide advice and referral<sup>17</sup>. Additionally, interpreter services and other communication difficulties can be frustrating for patients and health workers alike, and may significantly deter asylum seekers<sup>17,38</sup>. The Victorian Foundation for Survivors of Torture has prepared an in-depth report on the use of interpreters for people of non-English speaking backgrounds in health care settings<sup>103</sup>. It highlights the consequences of inadequate communication between a health care professional and clients, for example ineffective, time consuming and even dangerous interventions. Despite this, there remains some reluctance from some health professionals to use interpreters, even when they can be utilised at no additional cost<sup>103</sup>.

Refugee health issues are constantly evolving, depending on the countries of origin that they are fleeing. For example, five years ago the majority of asylum seekers and refugees were from African nations. Now, increasing numbers are fleeing the Middle East and so a new disease profile is emerging<sup>102</sup>. Health professionals working in the community may be unfamiliar with the kinds of medical conditions that are more prevalent among asylum seekers and refugees<sup>38</sup>. This was demonstrated in a survey of General Practitioners in South Australia<sup>104</sup>. Poor understanding can lead to inadequate assessment and treatment<sup>72</sup>.

This is further compounded by the fact that it can be extremely challenging to accurately record the medical history of new arrivals<sup>89</sup>. Other problems include the poor transfer of health information and inefficient or poorly developed referral systems<sup>62,72</sup>.

Finally, geography is another systemic issue, which is difficult to address. Like many Australian residents outside of metropolitan areas, asylum seekers face problems accessing services in regional and rural areas due to an absence of bulk billing services; lack of interpreters and female physicians; and lack of specialist care<sup>73</sup>. For those living in metropolitan areas, the cost of transportation can be high, as well as a challenge to navigate when new to the country<sup>73</sup>.

## Sociocultural barriers

Asylum seekers are an ethnically, culturally and linguistically diverse population group. They might have different health beliefs and behaviours or different attitudes towards prevention, treatment and expectations of health services<sup>105</sup>. The Australian health system, with a focus on the Western model of biomedical intervention, may be unfamiliar and daunting. Many health practitioners are likely to overlook the importance of the role of traditional healers and natural remedies in some cultures. Health care providers with poor cultural understanding may deter or even exclude certain ethnic groups from seeking assistance. Poor health literacy

due to difficulties accessing and understanding health-related information will affect asylum seekers' ability to make informed decisions<sup>99</sup>.

Due to traumatic past experiences and indeterminate visa status, asylum seekers may be fearful of contact with agencies and authorities, particularly those that are linked with government services<sup>105</sup>. Fear of medical procedures may be associated with experiences of torture<sup>60,81</sup>. Research by Coffey et al. found that many asylum seekers had difficulty trusting people and preferred to avoid social situations. Their vulnerability is likely to result in a reluctance to seek out additional support services<sup>17</sup>. Asylum seekers may face discrimination or stigmatisation by their community if they are identified as having a mental health disorder<sup>106</sup>. They may also have fears around seeking help if they believe a mental health diagnosis might influence immigration decisions or lead to a loss of employment<sup>106</sup>.

## The role of health professionals

Health professionals working with asylum seekers in the community are often simultaneously acting as advocates for their patients. In the community, health professionals dedicate considerable time and energy to negotiating fee waivers with other health service providers or trying to raise awareness of the issues surrounding asylum seeker health<sup>94,101</sup>. These people are integral to supporting the asylum seeker population. Medical practitioners are often sought out for non-health reasons by asylum seekers who are having difficulty with settlement issues. This was evident in the research by Correa-Velez et al. where social issues, such as immigration and welfare problems accounted for a considerable proportion of reasons for presentation<sup>21</sup>. Having to provide reassurance and advice on social issues is generally outside of the scope of a medically focussed health professional, but is an indication of the kind of holistic approach required to address the needs and vulnerabilities of asylum seekers in the community.

In the immigration detention centres, the situation is even more complex. A number of leading academics have raised concerns about the role that health professionals play when employed by the contracted medical service to provide care to detainees. Zion argues that some health care workers face a conflict between their duty of care to a patient and obligations to uphold the interests of a third party, usually their employer<sup>107</sup>. Codes of conduct and codes of ethics for health professionals are absolute, yet what contracted health professionals observe or must co-operate with, may challenge this<sup>108</sup>. Working in these facilities can result in a loss of autonomy and inability to protect the needs of their vulnerable clients. Briskman et al. assert that certain policies in detention constitute acts of torture, for example the forced feeding of people who are on hunger strikes, or the use of physical restraints<sup>108</sup>.

Many experts and professional bodies encourage collective action in advocating for the welfare of asylum seekers, particularly around the issue of mandatory detention<sup>107</sup>. There is also an awareness that staff themselves are at risk of suffering personal trauma and burnout when they are required to support people in considerable distress<sup>94</sup>. Training and support for people working with asylum seekers and collaboration between agencies is essential to ensure the sustainability of these services.



## Section 3:

# Environmental scan Overview of asylum seekers' health services and gaps



## Summary section 3

There are very few health services across the three states with specialised skills in asylum seeker health. The existing services are provided by a group of passionate, dedicated workers with a genuine interest in the welfare of asylum seekers. They operate with very limited budgets and often rely on volunteers and other pro-bono services.

The health of asylum seekers is intertwined with complex social needs and often affected by the visa determination process. Health workers must be flexible and willing to work beyond the standard model of care, including close collaboration with welfare agencies, to address these issues before asylum seekers' health needs can be addressed.

Access to primary health care is limited in some areas due to a lack of GPs willing to provide pro-bono or bulk billing services. The private practice model is not conducive to the needs of asylum seekers due to difficulties for GPs in providing long consultations with the support of interpreters and a multidisciplinary team. GPs also need support and education to ensure they are aware of health issues related to the refugee experience and can provide culturally appropriate care. Refugee health nurses in some states are able to address some of these service gaps but their scope of practice is limited.

Asylum seekers' access to mental health services is a major concern, particularly due to the increased number of asylum seekers being released from detention into the community on bridging visas. Despite the presence of high quality, dedicated torture and trauma services in each state, these services are stretched and remain relatively unsupported by the mainstream mental health sector. Few private mental health professionals have the appropriate expertise, access to free interpreters and the flexibility to provide ongoing, holistic care to asylum seekers; and current service models limit access to those without Medicare altogether. Innovative service delivery models are needed to increase the capacity of existing mental health services to meet the needs of asylum seekers.

Asylum seekers without Medicare are particularly disadvantaged in trying to access health care although fee waiver policies in Victoria and NSW have greatly reduced some of these access barriers. Pathology, imaging, pharmaceuticals, specialists and allied health practitioners can be difficult to access in the community for asylum seekers without Medicare. Services caring for asylum seekers often rely on ad-hoc pro-bono arrangements and interpersonal relationships to meet the needs of their clients. Services affiliated with tertiary hospitals find this significantly improves access for asylum seekers.

Health services with a refugee focus differ across Victoria, NSW and QLD, and the capacity to provide timely care for asylum seekers with and without Medicare can be driven by changing policies and service demand. Health professionals in all states are actively involved in trying to improve the current service models, particularly in QLD where funding and structural changes to the refugee health sector and a shortage of bulk-billing GPs have affected access to primary care for asylum seekers.



# Introduction

Section 3 aims to assist SVHA in strategic planning and prioritisation by 1) providing a summary of the concerns raised by service providers around mental and physical health needs of asylum seekers, service availability and barriers to accessing these services and 2) providing an overview of existing services providing health care for asylum seekers identified in Melbourne, Sydney and Brisbane.

It is important to keep in mind that the service structure and referral points for asylum seekers are not straight forward. Mostly, they rely on ad-hoc arrangements and interpersonal relationships between service providers; the capacity and willingness of some services to care for asylum seekers can evolve quickly depending on available human and financial resources. This section is simply an overview and a snapshot - further consultation is required to gain a clearer understanding of the provision of health services to asylum seekers.

Most of the information gathered for this section was obtained through consultation with representatives of service providers both in the health and welfare sectors in order to gain a better understanding of existing services available to asylum seekers across the three states and identify service gaps. Due to the limited time frame, only a fraction of people involved in the sector were able to offer their insight, however there was wide consensus around many issues. We would like to acknowledge the valuable contributions of staff from the following organisations:

**Table 5: Stakeholders consulted for this scoping study**

VICTORIA	NEW SOUTH WALES	QUEENSLAND
Asylum Seeker Resource Centre	Asylum Seekers Centre	Australian Red Cross – QLD
Australian Red Cross - Vic	Australian Red Cross - NSW	Mater Health Services
Department of Immigration and Citizenship, Victorian branch	House of Welcome	Multicultural Development Association
Hotham Mission Asylum Seeker Project	International Health and Medical Services	Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)
Refugee Health Service, Southern Health	Jesuit Refugee Service	Queensland Transcultural Mental Health Centre
Victorian Foundation for Survivors of Torture (Foundation House)	NSW Refugee Health Service	Refugee Claimants Support Service
Victorian Refugee Health Nurse Program	NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)	Social Justice Commission

## Medicare access

Access to Medicare is granted to asylum seekers who have permission to work (see section 5). Medicare access will generally be sustained if the asylum seeker remains lawful (e.g. has a valid substantive or bridging visa) and cooperative with DIAC. In summary, the asylum seekers groups that *generally* have access to Medicare include:

- Asylum seekers released from detention into the community on a bridging visa E
- Asylum seekers that arrived by plane with a substantive visa, apply for protection early and were granted work rights with their bridging visa (see section 5)

Asylum seeker groups that might not have access to Medicare include those who:

- Arrived by plane with a substantive visa but: whose visa expired before they applied for a protection visa; or who were unlawful or appeared to not be cooperating with DIAC. They may be denied work rights or subsequently lose work rights (and Medicare access)
- Arrived by plane and remain on a substantive visa, such as a tourist visa, without work rights since applying for protection (the bridging visa doesn't come into effect until the substantive visa expires)

There can be a several problems for asylum seekers registering with Medicare and maintaining a valid interim Medicare card. Some examples given include:

- General delays upon registration
- Not having enough identification
- Letters from DIAC not being worded properly
- Interim cards only being issued for short periods, particularly if the asylum seeker is on a 'negative pathway' (protection visa refused but unable or unwilling to leave Australia)

Other related policies:

- Asylum seekers cannot obtain a Health Care Card. This really limits their ability to pay for health service gaps, pharmaceuticals and means they might not be prioritised for some services
- Asylum seekers with ASAS/CAS, regardless of Medicare eligibility, will have their health care costs (equivalent to an Australian citizen with Medicare) paid for by Red Cross. This includes prescription pharmaceuticals at the Health Care Card cost
- See section 5 for more detail on these policies

## Health service types

*It can be difficult to identify health services providing care to asylum seekers because this is often embedded in existing service models for refugees, culturally and linguistically diverse (CALD) groups or even mainstream services. The following services that are explored in more detail are those that are specifically targeting the asylum seeker population. Many of these services are at capacity and have developed prioritisation tools or eligibility criteria to manage demand. In some cases, this leads to the exclusion of individuals in need.*

There are huge differences between states in terms of the service models catering for asylum seekers. While most services are community-based, others operate within tertiary settings in an outpatient capacity. Whether the service is specialised for asylum seekers or a generalist service with an interest in refugee health also differs, as does the nature of referral and collaboration with other health and welfare organisations. Some models are more medicalised, while others aim to address social and even legal needs concurrently with a team approach. The degree of research, education and training embedded within the service also differs as some become beacons of knowledge for the wider asylum seeker service community. Table 6 offers an overview of the health service models (adapted from Owen et al.<sup>109</sup>).

**Table 6: Health service models**

<b>TYOLOGY OF SERVICE MODELS</b>	<b>CHARACTERISTICS</b>	<b>BENEFITS AND LIMITATIONS</b>
GP primary care	Asylum seeker linked to a GP who undertakes initial health screen or comprehensive assessment and refers to other services as required.	This is the standard GP-led primary care model. Funding model will affect access: GPs in private practice may or may not be willing to bulk-bill asylum seeker clients with Medicare. GPs will receive no remuneration for asylum seekers without Medicare (i.e. pro-bono only).
Community health centre	Refugee linked to a multidisciplinary publicly funded community health centre (CHC). Staff at the CHC undertake initial health screen or comprehensive assessment and refers to other services as required. The CHC may run a refugee program.	This model works well because referral pathways are well established and asylum seekers will be able to access multiple services in one location including some counselling and allied health services. Capacity to see Medicare ineligible asylum seekers will vary.
Specialist community clinic or centre	Asylum seeker linked to a specialist centre on arrival that undertakes initial health screen and delivers initial services. Over time, links asylum seeker into appropriate primary care/mental health/ other specialist services as required but may continue to provide some specialist services onsite (e.g. torture and trauma).	Service providers are well-educated and trained around asylum seeker health needs. Medicare-ineligible asylum seekers may be able to receive ongoing care through this model. Often supported by local public tertiary hospital for pathology, imaging and some pharmaceuticals. Service demand schedule necessary to prioritise clients.
Refugee Health Nurse	Asylum seeker linked to a RHN who undertakes initial health screen, links into GP and other services as required and acts as ongoing case manager until the asylum seeker is ready for referral to mainstream services.	The RHN may be employed by a specialist clinic, CHC or tertiary service. RHN limited to basic assessment and referral to GP and some allied health; cannot undertake medical screening, prescribe or refer to specialists.
Hospital specialist clinic	Referral service for designated target group/s for specialist intervention, for example infectious disease, vitamin D therapy, paediatric care.	These services are for short-term intervention usually staffed by doctors and nurses with extensive experience working with asylum seekers, refugees, migrants and other CALD groups.
Specialist torture and trauma service	Asylum seekers receive care from mental health professionals with specialist training for people with refugee backgrounds. Programs may involve a counsellor-advocacy model or sessional psychologists and psychiatrists as well as many other programs for young people and families.	Intake assessments are necessary to determine eligibility and prioritise patients. May be long waiting lists due to high demand. Capacity to provide early intervention may be limited by available funding.
Specialist community mental health service	Asylum seekers self-refer or internally referred to receive mental health services from a counsellor, psychologist or psychiatrist through volunteer programs facilitated through asylum seeker support agencies.	These services rely on volunteers and the level of experience between mental health professionals will vary greatly. There may be eligibility criteria, for example restricted only to those without Medicare or ASAS and capacity to see clients long-term may be limited.

# Asylum seekers in community detention

Asylum seekers in community detention are not of primary concern to this report because they currently have their health needs facilitated by a private contractor – International Health and Medical Services (IHMS). In general, asylum seekers in community detention are a well-served group. They are entitled to have all their medical needs paid for. However, a number of service providers raised concerns specifically around access to health services for this group:

- In some geographical areas, IHMS has had difficulty engaging GPs, pharmacists, mental health workers and other health professionals required to provide services to asylum seekers. This has resulted in access delays or asylum seekers having to travel great distances to see a contracted provider elsewhere.
- At present, no formal screening and assessment program operates for families, children, unaccompanied minors and vulnerable adults entering the community detention program; however, many will have undergone medical screening on arrival. Case workers arrange an initial assessment with a GP in the community who is an IHMS contracted provider.
- IHMS contracted providers do not receive any training or education around asylum seeker health needs. Although some health professionals may offer their services due to an interest and background knowledge of asylum seeker health, it is likely that many do not have the appropriate skills to care for this vulnerable group.
- Unaccompanied minors and children have particular mental health needs that require a tailored mental health response. Their mental health problems are often related to the trauma from the journey and changed environment, so they don't really fit into torture and trauma services but rather require more general mental health treatment. There are currently no formal referral points for these services and it is unclear what is being provided to children and adolescents through the community detention arrangements. Mainstream child and adolescent mental health services are already inundated with referrals and do not have the appropriate training around asylum seeker issues.

## Health Needs of, and health services for, Asylum seekers in the community

The following sections outlines some of the themes that emerged through consultation with health and welfare service providers around the health of asylum seekers who are living in the community (not community detention) and their access to health services. Many of these organisations are members of the Refugee Health Network of Australia (RHeaNA) which was formed to improve access to health care for asylum seekers and encourage communication between health care providers and policymakers to advocate for the needs of asylum seekers and refugees. RHeaNA is a collaboration of over 140 health service providers around Australia including GPs, nurses, specialists, academics, advocates and policymakers<sup>110</sup>.

### Health concerns

In general, asylum seekers in the community present with similar general health issues to refugees arriving through the offshore program. Most health services are currently seeing an increase in service demand due to the number of asylum seekers being released from immigration detention into the community. This increase was unannounced and unexpected and therefore health services are unable to plan for a sudden increase of demand. Health screening and assessment during the detention period usually means that these clients are in fairly good *physical* health and their immunisation status is adequate.

Consistently, consultations with people working in the health and welfare sector, revealed major concerns about the mental health of asylum seekers in the community. As explored in section 1 and 2, asylum seekers in general are vulnerable to mental illness due to: previous persecution, torture or trauma in their country of origin; the distressing nature of the journey to Australia; time spent in immigration detention centres; the uncertainty of the visa determination process; social stressors in the community such as insecure housing, employment and income; social isolation; and other settlement issues.

Some groups within the asylum seeker population appear to be particularly vulnerable to mental health problems. The first group concerns asylum seekers released from detention on bridging visas that have been detained for long periods of time, with longer detention periods resulting in poorer outcomes. They do not receive a huge amount of support upon release, despite the fact that some have become 'institutionalised' and require intensive casework support. The second group are those who have received a rejection of their visa application (often referred to as being on a 'negative pathway'); anecdotal evidence suggests this group are at much higher risk of self-harming and suicidal ideation. Unfortunately, because their protection application has been 'finally determined', they often lose access to support and health services, which further exacerbates their fragile state. They may be less likely to make contact with services for fear of being placed in detention or deported.

## Primary health service availability

Asylum seekers with Medicare can, in theory, access primary care services like any other Australian citizen. In reality though, this can be quite a challenge unless the individual is living in an area where the health needs of refugees and asylum seekers have been recognised and addressed through targeted, well-resourced programs.

- It can be difficult to engage GPs in private practice outside of the refugee health sector to care for asylum seekers due to: the need for longer consultation times; language barriers and the need to use interpreters; the complexity of their general health, mental health and social needs; poor attendance rates; and inability for most asylum seekers to pay gap fees.
- The willingness of GPs to bulk-bill asylum seekers with Medicare or waive fees for those without, is highly individualised and dependent on their awareness of asylum seeker issues more broadly and the degree of other service demands.
- In the absence of Health Care Cards, some asylum seekers may not be recognised as low-income earners and private providers may charge a gap or refer them for other private fee-paying services. In states where there is a public hospital fee-waiver for asylum seekers, the emergency department of a public hospital may be utilised if there are significant barriers to seeking care in the community.
- The expansive roles of Refugee Health Nurses are integral to filling some of the primary care gaps, however they are limited by their scope of practice and resource demands.

## Mental health Service availability

For most Australian citizens, access to care by mental health professionals that do not request the payment of a gap fee is limited. This situation is even more challenging for asylum seekers that have unique and complex mental health needs, require culturally-appropriate services and often an interpreter. Especially for asylum seekers without Medicare, there are very few options. Unfortunately, the current services available are just not adequately prepared for the recent sudden and unexpected growth in numbers.

- In each state, there is a specialist torture and trauma service which together form the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT). These services are leaders in the field, offering high quality care for asylum seekers and refugees. However, due to high demand they have a limited capacity, and asylum seekers with acute mental health needs not directly related to torture or trauma are not eligible for their services.

- Outside of FASSTT services there are a few dedicated but small pro-bono mental health services, often run through asylum seeker support agencies. However, despite the high quality and dedication of these services, there is still an unmet need due to high service demand. Long-term planning and continuity of service provision can be challenging when human and financial resources are inconsistent due to the reliance on donations, small community grants and volunteer staff.
- Mainstream community mental health services are generally unaware of the unique needs of asylum seekers and the complex interaction of social factors affecting mental health, and are unlikely to provide culturally-appropriate care. There is some reluctance from these services to increase their involvement as they are already under pressure to service the general community.
- Acute crisis support for asylum seekers is limited: community crisis teams, emergency services and inpatient psychiatric units have very high thresholds of response and do not currently understand the complexity of asylum seeker mental health needs. In some areas though, where asylum seeker populations reside, expertise has developed through on-the-ground experience.
- It is challenging to engage more private psychologists and psychiatrists because there are few with the appropriate expertise and free access to translator services as well as difficulties with remuneration, particularly for asylum seekers without Medicare.
- Due to the rapid rise in numbers of asylum seekers released from detention, some case workers who are supporting asylum seekers are overburdened and struggling to respond to the ongoing needs of asylum seekers. In addition, they may be unprepared for dealing with clients in acute mental health distress.
- There are major gaps in mental health services for children and adolescents with no mainstream services identified as having targeted programs for asylum seekers who are minors, or adequate knowledge of their complex needs.

## Specialist service availability

### Investigations

Asylum seekers with Medicare can request to be bulk-billed for most pathology and imaging and be referred appropriately, like other Australian citizens. The situation is much more difficult for asylum seekers without Medicare though, as formal arrangements must be established between a service provider and a private provider, unless the patient is within the public hospital system in NSW or Victoria. There remain ongoing problems with Medicare-ineligible asylum seekers being billed, which can cause considerable distress and require negotiation on their behalf from a patient advocate.

Clinics catering for the needs of refugees and asylum seekers are sometimes co-located within a wider tertiary health service which they rely on to cover the cost of pathology and imaging. There are other clinics, like the Asylum Seeker Resource Centre in Victoria, the Asylum Seekers Centre in NSW, or the NSW Refugee Health Service that are independent of a tertiary service and must therefore develop agreements with private companies or a local hospital to ensure Medicare-ineligible patients can have investigations undertaken.

### Pharmaceuticals

The cost of pharmaceuticals can be a huge burden for asylum seekers and some may choose to cease treatment if the cost is inhibitory. Access to the PBS through Medicare and ASAS/CAS subsidisation greatly assist some asylum seekers but many remain unable to afford the gaps, particularly if a number of medications are prescribed concurrently. For asylum seekers without Medicare, medications are rarely affordable as they are not provided at the PBS price. Organisations trying to cover the costs of pharmaceuticals find this a huge cost burden.



Those released from immigration detention requiring ongoing medication are often only provided with an interim supply (usually 14 days) and are expected to make arrangements to obtain scripts and medication in the community within that time frame. This is often not realistic and poses a significant risk, especially when it concerns medication for serious illnesses.

## Allied health services, Specialist health services and chronic disease management

Due to the fee waiver directives in Victoria and NSW, asylum seekers without Medicare can access some specialist, allied health services and chronic disease management through public hospital ambulatory care clinics with GP referral. There may be long waiting lists to be seen in outpatient clinics and not all specialties can be accessed as outpatients. It is not clear how these services can be accessed in Queensland for asylum seekers without Medicare. Access to pro-bono private specialists relies on interpersonal relationships and knowledge, so is not sustainable long-term. Some organisations are trying to establish databases on allied health and specialist practitioners willing to provide free services, however they are wary of overburdening any one provider.

### Dental Services

Access to basic dental care has been consistently highlighted as a major service gap. Asylum seekers often have very poor oral health and most have not received basic dental care for many years. The needs of asylum seekers has been acknowledged by the National Dental Foundation and 'dental rescue days' are offered across the states about three times per year. In Victoria, asylum seekers have been recognised as a priority group and they can access basic dental care through Royal Dental Hospital and community clinics regardless of Medicare status. In NSW, a dedicated dental clinic has been established at one of the dental hospitals but they are only willing to see asylum seekers for emergency and urgent care. In Queensland, it appears that asylum seekers only have access to a free dental clinic held twice per year.

### Optometry services

Asylum seekers with Medicare can access free eye checks. Those without Medicare can usually also access eye checks through academic institutions offering student training. However if an individual requires spectacles, the cost can be prohibitive even when offered at subsidised rates. Some optometry services are run through community health centres in Victoria.

## Barriers to accessing Health Services

### Barriers to accessing Primary health services

- Asylum seekers are often in unstable environments with little or no income, insecure housing, and many have minimal social supports. This can contribute to poor health, as is discussed in section 1, but also means that health care takes little priority.
- Navigating the health care system can be challenging for asylum seekers that are not familiar with the Australian model and may be fearful of authority or worried about being charged for services. This means that asylum seekers are less likely to seek out health services as required, and underlying health problems may be ignored until they require immediate attention, with potentially devastating consequences.
- It can be difficult to engage asylum seekers that are not actively seeking out existing services. For asylum seekers released from detention, formal orientation processes enable registration and initial case work support. By contrast, asylum seekers arriving by plane receive no formal orientation and may subsequently be a more 'hidden' population group.

- Due to language barriers and unfamiliarity with the Western biomedical model of health, many asylum seekers have poor health literacy. Service providers find it challenging to explain disease processes and some patients may become non-compliant with treatment.
- The geographic location of a service is an important consideration. Asylum seekers may be willing to travel a long distance to access services if they feel comfortable and confident about the quality of the service, however transportation costs and ease of access with public transport will affect willingness to travel.
- Asylum seekers without Medicare are still being billed for services in some cases due to a lack of awareness in Victoria and NSW about the state department of health fee waiver directives. This can be distressing for the patient, while negotiation and advocacy on behalf of the patient who has been billed is time consuming and frustrating for service providers. This is much less likely to occur in areas where organisations and services are familiar with the needs of asylum seekers.
- Poor sharing of health information between governmental, contracted and community-based organisations caring for asylum seekers can lead to duplicated investigations, a lack of follow up treatment and inefficiency.
- Outside of specialist refugee and asylum seeker services, there is poor understanding of conditions more prevalent among this group than the general population, such as infectious diseases, nutritional disorders or somatic symptoms and chronic pain as manifestations of underlying mental health problems. Improved refugee health knowledge and understanding of alternative cultural understandings of health can assist health professionals to provide high quality care.
- Health practitioners may not be aware of how to identify and appropriately refer asylum seekers and need ongoing professional development around the changing needs of this client group.

## Barriers to accessing Mental health services

- Most asylum seekers are unlikely to recognise mental health problems and subsequently, very few self-refer for mental health services. There is no routine, mandatory screening in place and so psychological morbidity may remain undetected among many asylum seekers.
- In some cultural groups, there is stigma associated with mental health and a poor understanding of what treatment involves. This can make it challenging to engage asylum seekers in early intervention and appropriate treatment.
- Mainstream community mental health services are described as being ‘diagnosis-driven’. It can be difficult to get these services to recognise the “legitimacy” of asylum seekers’ mental health problems. It is commonly accepted that some mental health issues are directly related to the visa process, which is out of the person’s (and service provider’s) control and is time dependent. Subsequently, some mental health services are reluctant to engage in treatment until the contributing factor is resolved (i.e. their visa status).
- Asylum seekers are unable to afford private mental health services and there are very few with the appropriate expertise, willingness to bulk-bill or use interpreters.

## Barriers to accessing Interpreters

Many organisations feel that ready access to interpreters promotes health equity, health literacy and encourages positive help-seeking behaviour, however:

- There is a need for improved access to interpreters throughout state and Commonwealth-funded health services - not all health professionals are entitled to access the National Translator and Interpreter Service (TIS) for free. For example, allied health practitioners including psychologists and social workers providing MBS-funded mental health programs don’t have access to fee-free TIS. Some allied health practitioners in community health centres will be able to utilise interpreter services because these costs are accounted for in wider service budgets.



- Factors related to difficulties accessing interpreters include: reluctance from health professionals; poor understanding of how to work with interpreters; delays in accessing telephone interpreters; inappropriate use of family members as interpreters; and lack of awareness of eligibility and rights of the patient.
- Health services without fee-free interpreter services find this contributes substantial costs and so may be an inhibitory factor for seeing asylum seeker clients.

## Service models required to meet the needs of asylum seekers

- General and mental health professionals need to work outside of their usual model of care and collaborate with welfare organisations to help manage asylum seekers' complex psychosocial needs, including settlement issues, before health needs can be addressed.
- Appropriate delivery of mental health services for asylum seekers requires a "counsellor-advocate" model, like is used through FASSTT services. This model assumes for every mental health consultation, at least double the time is required for follow up work due to the complexity of asylum seekers' social needs. It is difficult for private practice models to accommodate this kind of holistic approach unless social workers or case workers are present onsite.
- In order to assist in identification and referral of asylum seekers, routine screening of mental health risk should be embedded into the service delivery model. Training and education around screening could be developed for utilisation both within and outside of the health sector.
- To maintain engagement of asylum seekers on a negative pathway, or others fearful of engaging with services, services need to build trust with the asylum seeker community and commit to supporting them along their journey. Outreach services and case workers willing to go to extra lengths to work with this vulnerable group are necessary.
- Although acute mental health crises are an issue of concern, a model that involves crisis intervention and after-hours services would be too costly considering the size of the population of concern. A more appropriate solution could be a mental health first aid course for people who work with asylum seekers. A short course could train and educate case workers and health workers in how to respond appropriately to acute mental health crises.
- Difficulties accessing mainstream community mental health services is a challenging issue to address. Capacity building across the state would be an inefficient and costly way of dealing with the problem considering the small number and distribution of asylum seekers, and the existing demand on these services from the general population.

The best model to improve general mental health services for asylum seekers requires a multidisciplinary, integrated approach. This would involve:

- Identification and training of consulting psychiatrists/psychologists with an interest in asylum seeker mental health and the provision of appropriate remunerative incentives to maintain continuity of care
- Ongoing training of GPs and refugee health nurses or practice nurses located in areas where asylum seekers reside to conduct mental health assessments
- Ongoing training of counsellors working in areas where greater numbers of asylum seekers are residing

- Establishment of additional specialist mental health services for asylum seekers with a multidisciplinary team including psychiatrists, psychologists, counsellors, mental health nurses and social workers. Ideally it would involve partnership and collaboration with existing services and operate on a case management model with clinical governance. It could operate a number of units within key geographical areas, where asylum seekers tend to settle, and extend services with outreach. Staff could consult externally and provide support to other mental health workers treating asylum seekers in the community.

## Overview of policies and providers: Victoria

### Department of health policy

The Department of Health Victoria, remains committed to improving service quality and access for refugees and asylum seekers. In 2008, the Refugee Health and Wellbeing Action Plan was released and outlined a number of new initiatives and strategic approaches in the refugee health sector<sup>111</sup>. This report acknowledges the vulnerability of asylum seekers, in particular those without Medicare access. At present, another refugee health and wellbeing strategy is being developed by the Department of Health Victoria in collaboration with the Victorian Refugee Health Network through extensive community consultation<sup>112</sup>. In early 2013, the Victorian government committed an additional \$670,000 to support the critical health needs of asylum seekers and refugees newly arrived to Victoria.

Victoria does not have a state-wide refugee health service, like NSW or Queensland, but the general and mental health needs are being addressed by a range of services under different models. In general, services for asylum seekers in the South-East are much more well-established and proactive in addressing new issues. Tertiary and community health centres and Medicare Locals have been developing innovative strategies and piloting programs to manage the increased numbers of asylum seekers and to ensure they are linked in with appropriate services upon release into the community.

A number of networks and working groups have been established in Victoria among organisations working with asylum seekers and refugees. They meet regularly to discuss current challenges in the sector and to plan for service improvement. Some examples include:

- Victorian Refugee Health Network (VRHN)
- Network of Asylum Seeker Agencies in Victoria (NASAVic)
- Dandenong Refugee Health Advisory Network
- Asylum Seeker Strategic Health Planning Network

In 2005, the Victorian Department of Health became the first state in Australia to change their regulations to allow Medicare-ineligible asylum seekers to have fees waived on a range of public health services<sup>113</sup>. Their directive is the most comprehensive and transparent of all states and was last updated in May 2011. The following section outlines the details of what service should be covered through this policy.

Currently, the Red Cross in collaboration with Medicare Locals, primary health providers, community health centres, refugee health nurses and the Victorian Refugee Health Network, are trialling a Health Orientation and Triage model in the areas where asylum seekers are settling following release from detention on a Bridging Visa E. The sessions cover a range of topics to support asylum seekers as they transition into the community. At the same time, they are assisted to register with Medicare and can access a nurse or doctor for 'health triaging'. Based on their health needs, the nurse or doctor will make arrangements for follow up at an appropriate service.

## Public Hospital Services

Through the public hospital system, Medicare-ineligible asylum seekers can access full medical care; both emergency and elective. This includes pathology, diagnostic, pharmaceutical and other services in Victorian public hospitals as either admitted patients or non-admitted patients.

As non-admitted patients, Medicare-ineligible asylum seekers may be billed for:

- Spectacles
- Hearing aids
- Surgical supplies
- Prostheses
- Aids/appliances/home modifications until they are eligible (30 days post- discharge) for the Department of Human Services' Aids and Equipment program.
- Pharmaceuticals supplied upon hospital separation, consistent with the PBS

Hospitals may choose to extend their level of service over that outlined above, at their own discretion.

## Ambulance Services

Asylum seekers in the community who have no capacity to pay will have free access to emergency services for emergency transport. An invoice will be written off when Ambulance Victoria receive confirmation from an asylum seeker support service of the patient's status and inability to pay.

## Community health services

Community health services are under increasing pressure to meet the demand for their services. In response to this, Generic and Clinical Priority Tools have been developed to establish a client's priority level, based on their clinical needs and/or social or economic disadvantage. Refugees and asylum seekers are priority 1 for community health services, so should be seen as quickly as possible.

## Immunisation

The responsibility of immunisation services are shared between the Commonwealth and State governments. Like all Australian children, asylum seeker children can receive free childhood vaccines. The Victorian government has developed a guideline on the provision of free immunisation to people who present with no documented vaccine history as part of a special program called the "Refugee-catch up immunisation program"<sup>114</sup>.

## Asylum seeker health services: Melbourne

In Victoria, there are a wide range of organisations that have tailored their services to cater for the needs of asylum seekers living in the community. Unlike NSW and Queensland, there is no state-wide service. *The following is a brief overview of general and mental health services - more detailed information is located in Appendix C for readers with a particular interest in this area.*

The major primary care service providers are the Asylum Seeker Resource Centre (ASRC) Health Centre (West Melbourne), which specifically looks after Medicare-ineligible asylum seekers and those without income support; and the Casey Cardinia Asylum Seekers and Refugee Health Clinic which is part of Southern Health's refugee health service and was established in response to the growing needs in the South East of Melbourne. These clinics are supported by a variety of community-based health centres, Refugee Health Nurse and Refugee Fellow programs and specialty clinics located at the Royal Children's Hospital and The Royal Melbourne Hospital.

The major mental health service provider for asylum seekers is the Victorian Foundation for Survivors of Torture (VFST), which is a member of the FASSTT network and is a leader in the provision of culturally sensitive services for people of a refugee background that have experienced torture or trauma. In addition, they are actively involved in the refugee health sector through advocacy, training and development of resources. The ASRC also have counselling and psychiatry services for asylum seekers, which are run with enormous support from volunteers. These services receive little support from mainstream mental health services, due in part, to issues identified earlier in this section.

## Overview of policies and providers: New South Wales

### Department of health policy

In February 2011, the Department of Health NSW released the Refugee Health Plan 2011-16<sup>115</sup>. The document outlines strategic priorities including the development of policies that: promote refugee health and wellbeing; improve health assessments for newly arrived refugees; foster high quality specialist services; and encourage research and evaluation. Throughout the Refugee Health Plan, the specific needs of asylum seekers are frequently acknowledged. In March 2011, the Department of Health NSW committed over \$6 million into refugee health over four years, which includes the expansion of the state-wide Refugee Health Nurse program<sup>116</sup>.

The health networks identified as being involved with asylum seekers in NSW include the Refugee Health Improvement Network, the NSW Asylum Seeker Interagency and the NSW Refugee Nurse Network. They do not appear to be as formally structured or actively involved as the Victorian Refugee Health Network but remain committed to supporting this vulnerable group.

### Hospital Services

In October 2009, the NSW Department of Health released a policy directive that requires all NSW public hospitals and mental health services to waive fees for community-residing asylum seekers who are not eligible for Medicare<sup>117</sup>. This directive was modelled on the Victorian policy and includes the following services:

- Emergency care for acute medical and surgical conditions, including admission
- Elective surgery for conditions listed as Clinical Priority Categories 1 and 2. This excludes Category 3 conditions in most circumstances (for example, spinal fusion, total hip replacement, hernia repair) as well as Cosmetic and Discretionary surgery
- Ambulatory and outpatient care required to maintain health status of asylum seekers with acute and chronic health conditions (e.g. diabetes)
- Maternity services, including antenatal care
- Inpatient mental health services

Procedure advises hospital staff on how to identify Medicare-ineligible asylum seekers through documentation but also states they may exercise discretion in the absence of definitive identification. The policy directive encourages staff to refer asylum seekers to a social worker or refugee health nurse and to link them with an asylum seeker support agency. The importance of utilising interpreter services is highlighted<sup>117</sup>. In addition, NSW hospitals are required to record the number of presentations made by Medicare-ineligible asylum seekers at admission. This differs from Victoria and Queensland where, to our knowledge, no data are routinely collected.

According to service providers consulted in NSW, awareness of the policy directive can be challenging at times, particularly with restructuring and changing staff within hospitals. The NSW Refugee Health service has been proactive in reminding services about the directive and requesting distribution of the document within hospitals.

## Ambulance services

In their Patient Hardship Policy, Ambulance Service NSW will “consider the waiving of charges” to people who have been granted or are applying for refugee status, with evidence from an appropriate authority<sup>118</sup>.

## Dental services

In NSW, asylum seekers without Medicare may be eligible for fee-waivers for the following oral health services, provided that a referral is made by an established agency<sup>119</sup>:

- Emergency oral health treatment at a public oral health clinic or hospital emergency department
- Urgent oral health treatment comprising an episodic course of care provided by the a public oral health clinic

This means that Medicare-ineligible asylum seekers are not eligible to access basic dental care for free except on dental health days offered through the National Dental Foundation

## Asylum seeker health services: Sydney

*The following is a brief description of available services for asylum seekers in NSW. Appendix D contains greater detail and can be referred to for further information.*

NSW have established a state-wide service, the NSW Refugee Health Service, to specifically cater for the needs of refugees and asylum seekers. This is mostly facilitated by refugee health nurses and has been expanded with additional funding from the NSW Department of Health. The Refugee Health Nurse program operates at 10 different locations across Metropolitan Sydney. Primarily the aim of this program is to facilitate health screening for newly arrived refugees, although community-residing asylum seekers can also access the service.

In addition, the Asylum Seekers Centre (ASC) operates a nurse-led clinic with a visiting volunteer GP for asylum seekers without Medicare. The opening hours of both of these clinics are limited so there can be major challenges finding pro-bono and/or bulk-billing GPs with an interest in the welfare of asylum seekers. As a result, both of these service tend to care for Medicare-ineligible patients until their visa status is resolved, rather than referring them onto community services, although this would be preferable. The ASC is supported by St Vincent's & Mater Health Sydney, which provides a pharmacy service, imaging, pathology (via a private provider), access to pro-bono medical specialists and in-patient services as required to asylum seekers with urgent health needs who are not eligible for Medicare.

Currently (March 2013), Medicare Locals are involved in conducting population health needs assessments. It is likely that this process will flag some issues with refugees and asylum seekers in areas where they predominantly reside and strategies and training may be put in place to address some of these needs.

Like Victoria, asylum seekers rely on the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) to access support for mental health problems related to past refugee experiences. The waiting list is long though and it can be very challenging to refer patients elsewhere for mainstream mental health services that are appropriate for asylum seekers. Occasionally, the NSW Transcultural Mental Health Centre can conduct initial assessments with asylum seekers but they do not have the capacity to provide ongoing care. The ASC have a very small counselling service for their eligible client group.

# Overview of providers and policies: Queensland

The provision of health services to asylum seekers residing in Queensland is not as well established as in Victoria or NSW. In general, service planning documentation, such as the Queensland Health Strategic Plan for Multicultural Health 2007–2012<sup>120</sup>, do not give significant weight to the health and service needs of asylum seekers or refugees more broadly. The Queensland Health Multicultural unit, previously responsible for multicultural health planning, no longer exists and these responsibilities have been transferred to the Strategic Policy Unit of Queensland Health. Other recent structural changes affecting policy and service planning will be discussed below.

To ensure that the needs of asylum seekers continue to be met, it will be important to ensure that strong policy is put in place that sets clinical standards and expectations in each region. Some of the organisations identified as being actively involved in capacity building around refugee and asylum seeker health and wellbeing include:

- Queensland branch of Refugee Health Network Australia (RHeaNA)
- Multicultural Development Association (MDA)
- Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)
- Mater Hospital
- Greater Metro South Brisbane Medicare Local (GMSBML)
- Australian Red Cross

## Queensland Health fee-waiver policy

For Medicare-ineligible asylum seekers, no new directive has been provided from the Department of Health Queensland with regards to accessing public hospital services. In May 2006, a policy memorandum was circulated that indicated hospitals should waive fees for asylum seekers on the following services, equivalent to what is covered by Medicare including:

- Inpatient services (including Intensive Care, Coronary Care, theatre, accommodation and medical fees)
- Care providing in emergency departments
- Outpatient services
- Pharmaceutical items and other incidentals required

To our knowledge, this memorandum has not been updated and people working with asylum seekers are following the status quo unless otherwise advised. In Queensland, organisations like QPASTT and those involved in the refugee health network have been lobbying to improve access to services for Medicare-ineligible asylum seekers in the community, similar to what is provided in Victoria and NSW.

## Asylum seeker health services: Brisbane

*The following is a brief description of available services for asylum seekers in Queensland. Appendix E contains greater detail and can be referred to for further information.*

In Brisbane, health service availability for non-Medicare eligible asylum seekers is limited. There is only one dedicated service that provides primary care services to asylum seekers: the Mater Health Services funded Extended Care Clinic co-located with the Brisbane South refugee health clinic at the Mater. Although there are other refugee health clinics funded by Department of Health in Logan, Toowoomba, Cairns and Townsville, these clinics are only funded for refugees granted Permanent Visas and for the most part, are nurse-led clinics which refer to general practice for medical assessments. In Brisbane South, there are historically low numbers



of GPs willing to bulk-bill patients or who are willing to see Medicare-ineligible asylum seekers. Despite efforts to engage and train GPs, there is limited capacity in refugee health. This area differs to Logan, which is recognised as a lower socio-economic area and there are more mixed billing practices. In Logan, the refugee clinic has formed good relationships with local GPs and the Medicare Local maintains a strong presence around refugee health. The Greater Metro South Brisbane Medicare Local is actively collaborating with key stakeholders in developing new models of care and hosting a refugee primary health providers working group. This group is looking at clinical issues and building primary health care capacity through training, resource development and identifying policy and research issues. A part time clinical lead has been funded by the GMSBML until June 2013 to support this work in partnership with the Mater UQ Centre for Primary Health Care.

Asylum seekers face the same difficulties accessing mental health services as in Victoria and NSW. The Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT) offers specialised torture and trauma services. QPASTT is a member of the FASSTT network and is a leader in the provision of culturally sensitive services for people of a refugee background that have experienced torture or trauma. They work in collaboration with the Queensland Transcultural Mental Health Centre at different times. However, one of their constant challenges is referring asylum seekers to mainstream mental health services given that there are not many available and prepared to work with this client group.

## Refugee Health Queensland restructure

Within the last 18 months there have been a number of major structural changes in Queensland's health system. With regards to refugees and asylum seekers, most notably the decentralisation of services, including Refugee Health Queensland, which previously played a major role in clinical consultation and capacity building. A service plan was established for the state-wide refugee health service in April 2008, but this plan is no longer relevant and there is no state-wide approach to refugee health care in Queensland.

Since the restructure, refugee health clinics now operate independently within various districts run by Hospital and Health Services (HHS) Boards; the exception being the Brisbane South refugee health clinic which is managed by Mater Health Services. These clinics aim to provide nursing assessments to newly arrived refugees (within first six months of settlement) and where possible, eligible asylum seekers. Of interest to this scoping study are clinics in South Brisbane, North Brisbane, Logan and Toowoomba. Within the South Brisbane clinic, there is an Extended Care service, which can provide services to asylum seekers without Medicare. Asylum seekers accessing the extended care clinic must have an active protection visa application. The service is more clinically-focussed; they do not have the capacity to support any social workers or a multidisciplinary team.

With the establishment of Hospital and Health Services boards and Medicare Locals, there is an expectation that decisions will be more localised and targeted to the local population. However the inherit risk for refugee health is that there is no critical mass at local district level and integration of care across services and districts is critical to meeting the complex needs of refugees and asylum seekers and maximise the resources required. These structural and funding changes have highlighted a number of concerns in the refugee and asylum seeker health sector:

- Devolving of the service to the districts means that they are responsible for their own budget decisions and may not recognise the needs of refugees and asylum seekers especially as there is no overarching refugee health policy framework
- Each district hospital is responsible for delivering the service and there is no overarching governance
- Contracts require these services to continue to see refugees but existing organisations are concerned about their capacity and willingness to do so long-term and also meet the needs of new demographics eg. Bridging Visa E (BVE) holders

- The dismantling of Refugee Health Queensland means that knowledge sharing and consultation is limited to services unfamiliar with refugee health issues
- Refugee health nurses are increasingly struggling to meet the expanded need and require a more flexible model to meet the needs of new arrivals especially BVE holders

## Primary care planning working group

In Brisbane South, Mater Health Services has engaged with various stakeholders including the Medicare Locals and NGOs to establish a Partnership Advisory Group for Refugee Health in Brisbane South. Two working groups, a service providers working group and a refugee primary health providers working group, have been established which feed into the Partnership Advisory Group. The focus of the work is on identifying the gaps, developing models of care and providing some strategic direction to assist in delivering integrated refugee health care and capacity building in primary care. Outputs thus far include: documenting the patient journey, developing the Materonline refugee health website, working with primary health care providers to develop refugee health clinics along the Beacon practice model, training and education events and responding to policy issues by preparing formal submissions. A way forward for refugee health is to implement the Beacon Practice model and build the skills of key general practices located in areas easily accessible to refugee populations. Refugee health nurses can provide outreach support to general practice and work collaboratively to address the complex health needs of refugees and asylum seekers.





## Section 4:

# Identification of the human rights context regarding asylum seekers in Australia

## Summary section 4

Australia has obligations to provide protection to people fleeing persecution, and those who have fled their homes to protect their family from a similar fate, irrespective of how they arrive, even if their entry is without authorisation. Protection of asylum seekers should be guaranteed by Australia if a range of risks are experienced including being subjected, or at risk of being subjected to the threat of death, torture, or cruel, inhuman or degrading treatment.

As a party to several United Nations human rights conventions and treaties, Australia has agreed to ensure that people who meet the UN's definition of refugees are not to be forcibly returned to a country where their life or freedom is threatened and to enjoy rights established in the following UN Human Rights Treaties:

- The United Nations Convention relating to the Status of Refugees (Refugee Convention)
- The International Covenant on Economic, Social and Cultural Rights (ICESCR)
- The International Covenant on Civil and Political Rights (ICCPR) and its Second Optional Protocol aiming at the abolition of the death penalty
- The International Convention on the Elimination of all Forms of Racial Discrimination (ICERD)
- The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)
- The Convention on the Rights of the Child (CRC).

While these conventions bear directly upon the right to access health care, adequate housing and income support/employment for asylum seekers, there is an absence of a formal domestic legislative framework in Australia that protects the rights asylum seekers are entitled to under these treaties.

The fulfilment of the right to health without any form of discrimination is linked to the actualisation of other human rights such as the right to housing and work. In Australia, however, not all asylum seekers are eligible for Medicare, housing support and work rights. With limitations around housing support, access to a financial safety net, opportunities of earning an income; and the policy vacuum into which they fall as a result of their immigration status, the safety and well-being of asylum seekers is compromised. In light of the above, Australia's immigration law, policy and practice continues to raise serious concerns in relation to its obligations under the above UN Human Rights Treaties.

To bring Australia more fully into compliance with its obligations under these UN Conventions, a range of policy changes are required to ensure that all asylum seekers, irrespective of their visa status, have access to the essential services required for an adequate standard of living such as medical services and treatment, an adequate and secure home, social security and employment.

## Introduction

As Australia is a signatory to and has ratified several UN human rights conventions and treaties pertaining to refugees and asylum seekers, section 4 provides an analysis of the broader human rights context impacting asylum seekers in the Australian community.

Section 4 is divided into three parts. The first presents an overview of the relevant human rights conventions and treaties Australia has signed and/or ratified that are relevant to asylum seeker health, housing and income support. The second part explores the challenges and human rights violations experienced by asylum seekers in Australia with reference to the obligations outlined in the relevant UN treaties and conventions. The third part identifies policy implications in seeking greater alignment with Australia's international obligations.

# Glossary

- Convention** This term is frequently employed for agreements or rules, whether general or particular, to which a large number of States are parties and are expressly recognised by them. Conventions are one of the main sources of international law recognised by Australian courts. The term Covenant is used interchangeably.
- Party** Party means a State which has consented to be bound and for which a treaty is in force. Australia must be a party to a treaty which has entered into force before its provisions are potentially applicable.
- Ratification** Ratification is confirmation of signature and signifies the intention to be bound by the provisions of a treaty.
- A Signatory** A signatory is a State which has signed an agreement. The agreement may not necessarily be in force for that State, or generally.
- Signature** Signature is the act whereby a State expresses its consent to the text of a treaty but not necessarily its consent to be bound by its provisions. Once a State has signed a treaty it is not obliged to ratify it. However, the Australian government's policy is not to sign a treaty without the intention to ratify it at a later date.
- Treaty** A treaty is an international agreement concluded in written form between two or more States (or other entities such as an international organisations having international personality) and governed by international law. A treaty, may take the form of a convention, an agreement or a protocol. In Australia, treaties are made by the executive arm of the Federal Government under the external affairs power given by Australia's Constitution, without permission needed by the Parliament. Treaty implementation requires legislation to pass through the Parliament to carry out or give effect to Australia's international treaty obligations, in whole or in part. It is for the Parliament not the courts to determine the method of implementation.

## UN human rights conventions and treaties signed or ratified by Australia

Part 1 of section 4 identifies UN conventions that Australia has signed and/or ratified and international obligations under them. It presents Australia's responsibilities as outlined in the covenants that are directly or indirectly linked to the policy areas of health care, housing and income support/employment.

### United Nations Convention Relating to the Status of Refugees

An asylum seeker is any person who has fled their own country and is seeking international protection as a refugee but their claim has not yet been determined<sup>121</sup>. Australia is one of 147 countries who are signatories to the *1951 United Nations Convention Relating to the Status of Refugees and its 1967 Protocol* ('the Refugee Convention')<sup>122</sup>. A protection visa may be granted to a person who is found to have protection obligations by Australia and meet the definition of a 'refugee' or the 'complimentary protection' criteria under the *Migration Act 1958*.

Under the Refugee Convention, a person may be owed protection if they are outside their country and are unable or unwilling to return due to a well-founded fear that they will be persecuted because of their:

- Race
- Religion
- Nationality
- Political opinion
- Membership of a particular social group

Central to the refugee definition is the ‘risk of persecution’, however this risk as indicated in articles 31 and 33 of the Refugee Convention encompass threats to an individual and/or families’ life or freedom, including the threat of death, torture, or cruel, inhuman or degrading treatment or punishment.

As the sixth country to agree to the Refugee Convention, Australia voluntarily ratified it on the 22 January 1954. Accession to the 1967 Protocol followed on 13 December 1973. The adoption of the 1967 protocol was to expand the scope of the Refugee Convention to ensure its relevance as the problem of displacement spread around the world and was not only confined to European refugees. The 1967 protocol recognised the international scope of the refugee crises as it removed the geographical and time limitations confining the original Convention’s focus to Europe after the Second World War. This turned the Refugee Convention into a universal instrument that provides protection to refugees everywhere.

Since 24 March 2012, under the *Migration Amendment (Complementary Protection) Act 2011*, Australia assesses asylum seekers claims for protection under ‘complementary protection’ criteria which states that a person is owed protection by Australia if they have substantial grounds for believing they will suffer significant harm if returned to their home country<sup>123</sup>. The criteria for complementary protection takes into consideration Australia’s broader international obligations beyond just those of the Refugee Convention and include if a person will be subject to:

- Arbitrary deprivation of his or her life
- The death penalty
- Torture
- Cruel or inhuman treatment or punishment
- Degrading treatment or punishment<sup>123</sup>

People who have left their country of residence or nationality due to war, famine, environmental collapse or to seek economic opportunities, but do not fear persecution, are not owed protection under the Refugee Convention. Nor is Australia obliged to protect those who already have effective protection in another country. Countries are not obliged to accept refugees for resettlement, but many do so as they willingly chose to take on that responsibility. Australia is one of 26 (mainly Western) countries participating in the United Nations High Commissioner for Refugees (UNHCR) resettlement program<sup>124</sup>.

As Australia is a signatory to the Refugee Convention, it is obliged to allow persons fleeing persecution, and those who have fled their homes to protect their family from a similar fate, to seek asylum and have their claims to refugee status processed. No penalties should be imposed on people seeking asylum in accordance with the Refugee Convention. It is not illegal to enter Australia to seek asylum, even if people arrive without authorisation or travel documents<sup>125</sup>. The Refugee Convention stipulates that penalties should not be imposed on refugees who arrive without authorisation or travel documents if they have come ‘directly from a territory where their life or freedom was threatened’ (Article 31(1)), which is of key significance to the issue of detention of asylum seekers arriving by boat to Australia. According to UNHCR, this includes not only refugees coming straight from their country of origin but also refugees coming from any other country where their protection, safety and security cannot be assured<sup>126</sup>.

As stated by Menadue et al.<sup>127(p.10)</sup>, Australia's obligations include:

*"To fairly and dispassionately consider the claims of those seeking asylum based on the definition of their well-founded fear of persecution. Not to punish a person because of the way they arrive in Australia, and if they are found to be a refugee, not to return that person to their home country."*

Implementation of these obligations however is difficult in Australian courts as the Refugee Convention is incorporated only by definition of the term 'refugee' in the *Migration Act 1958*. As stated by the Australian Lawyers for Human Rights Refugee Law Kit<sup>128(p.12)</sup>:

*"Australia has passed legislation to make it more difficult for asylum seekers to qualify for asylum as refugees under the Migration Act 1958. This means that refugees who may qualify for protection under the Refugee Convention may be turned away. Australia also treats some refugees differently from others, depending on factors such as how or where they arrived in Australia. Australia has also moved to limit access to the courts for review of administrative decisions on refugee status as well as to legal advice for asylum seekers."*

Obligations in the Refugee Convention that are linked to the policy areas of health care, housing and income support are established in the following articles: the right to engage in wage-earning employment with consideration to assimilating this right to those of nationals (article 17); the right to engage in self-employment including agriculture, industry, handicrafts and commerce and to establish commercial and industrial companies (article 18); the right to housing (article 21); the right to choose their place of residence and move freely within its territory (article 26); the right to access the same treatment accorded to nationals with respect to public relief and assistance (article 23) and the right to social security in respect to unemployment, family responsibilities and any other contingency which, according to national laws and regulations, is covered by a social security scheme (article 24).

In addition to the Refugee Convention, there are other international human rights conventions to which Australia is a party including:

- The International Covenant on Economic, Social and Cultural Rights (ICESCR)
- The International Covenant on Civil and Political Rights (ICCPR) and its Second Optional Protocol aiming at the abolition of the death penalty
- The International Convention on the Elimination of all Forms of Racial Discrimination (ICERD)
- The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)
- The Convention on the Rights of the Child (CRC).

## The International Covenant on Economic, Social and Cultural Rights

The *International Covenant on Economic, Social and Cultural Rights* (ICESCR) was adopted by the UN General Assembly on 16 December 1966 and entered into force on 3 January 1976<sup>129</sup>. This treaty covers almost all of the rights enshrined in the *Universal Declaration of Human Rights* (a non-legally binding document), with a focus on ensuring the protection of economic, social and cultural rights.

Australia ratified the ICESCR on 10 December 1975, and in keeping with article 2(1) is obliged to undertake steps, in accordance with the maximum of its available resources, to progressively achieve the full realisation of the rights recognised in this covenant.

Obligations in the ICESCR that are either directly or indirectly linked to the policy areas of health care, housing and income support are established in several articles, including: the right to non-discrimination based on race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (article 2); the right to work (articles 6–7); the right to social security (article 9); protection and assistance for the family (article 10); the right to an adequate standard of living (article 11); and the right to health (article 12)<sup>129</sup>.

## International Covenant on Civil and Political Rights 1966

A parallel convention that was also adopted by the UN General Assembly on 16 December 1966, to translate the *Universal Declaration of Human Rights* into binding legal form, is the *International Covenant on Civil and Political Rights* (ICCPR). The Human Rights Committee<sup>1</sup> prepared this treaty to set forth civil and political rights to complement the covenant providing for economic, social and cultural rights, the ICESCR. These covenants make up the *International Bill of Human Rights*<sup>130</sup>.

The ICCPR comprises all of the traditional human rights including the right to be free from torture and the right to a fair trial. Like the ICESCR, the rights established in the ICCPR are subject to reasonable limitations, for the purpose of protecting national security, public order or promoting the general welfare of a democratic society. However, there are rights in the ICCPR that are absolute – in particular the right not to be held in slavery and the right to be free from torture<sup>131</sup>.

While Australia ratified the ICCPR on 13 August 1980, subject to certain reservations<sup>2</sup>, the convention still does not form part of Australia's domestic law. However, monitoring Australia's compliance with the ICCPR is the responsibility of the Australian Human Rights Commission (AHRC) as the ICCPR is scheduled to the *Australian Human Rights Commission Act 1986*<sup>132,3</sup>.

The ICCPR has optional protocols that supplement the original convention with additional obligations. On 25 September 1991, Australia agreed to be bound by the First Optional Protocol to the ICCPR, which enables the UN Human Rights Committee to hear complaints from individuals who allege that the Australian Government has violated their rights under the ICCPR<sup>129</sup>. However, the concluding observations of the Human Rights Committee lack any binding legal force.

Obligations in the ICCPR that are either directly or indirectly linked to the policy areas of health care, housing and income support are established in several articles, including: the right to not subject anyone to cruel, inhuman or degrading treatment (article 7); the right to liberty of movement and freedom to choose one's residence (article 12); the right to a fair and public hearing by a competent, independent and impartial tribunal (article 14); and the right to the protection of children by society and the State as are required by their status as a minor and of families (articles 24 and 23, respectively).

## The International Convention on the Elimination of All Forms of Racial Discrimination

The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) 1966 was ratified by Australia on 30 September 1975<sup>133</sup>.

The ICERD defines racial discrimination and sets out a framework for ensuring that civil, political, economic and social rights are equally protected for all, without distinction of race, colour, descent or national or ethnic origin<sup>133</sup>.

To assist in giving effect to the ICERD, the Committee on the Elimination of Racial Discrimination (the ICERD Committee) was established to monitor the compliance of States Parties to the ICERD's articles, particularly with regard to the legislative, judicial, administrative or other measures a state has taken. The ICERD is scheduled to the *Racial Discrimination Act 1975*<sup>134</sup> which gives effect to Australia's obligations under the convention to promote equality before the law and make discrimination against people unlawful.

<sup>1</sup> At the international level, the Human Rights Committee is the principal actor mandated to enforce the rights enunciated in the ICCPR.

<sup>2</sup> A list of Australia's reservations can be accessed here <http://www.austlii.edu.au/au/other/dfat/treaties/1980/23.html>.

<sup>3</sup> Although the Commission has had the power to monitor and investigate alleged breaches of the ICCPR since 1986, it has no power of penalty or enforcement.



Obligations in the ICERD that are linked to the policy areas of health care, housing and income support are established in the following articles: the right to equal recognition, enjoyment or exercise, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life without any form of discrimination (article 1); and the right of everyone to enjoy civil, political, economic, social and cultural rights, regarding: freedom of movement; work; housing; public health and medical care (article 5).

## Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Australia became a party to the Convention *against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (the Convention against Torture, or CAT) in 1985 and ratified it on 7 September 1989<sup>135</sup>.

The CAT is monitored by the UN Committee against Torture which investigates individual and interstate complaints, and conducts inquiries into alleged violations of the Convention. Visitation of international inspectors to places where persons are deprived of their liberty is conducted by the UN Subcommittee on Prevention of Torture (SPT), a subsidiary body created by the Optional Protocol to the Convention of Torture (OPCAT), which Australia signed on 19 May 2009, but has not yet ratified<sup>136</sup>.

Although Australian law prohibits the use of torture in all its forms and there are mechanisms in place for inspecting places of detention, many of the mechanisms lack institutional, functional or practical independence. There are varying levels of oversight, as well as gaps in monitoring, which could be addressed once Australia becomes a full party to the OPCAT. Therefore, in signing the OPCAT, the Australian Government will be required to establish a National Preventive Mechanism – a national system of inspections to prevent and/or redress acts of torture and other forms of ill treatment in detention, including onshore and offshore immigration detention facilities<sup>136</sup>. Interestingly, the recent Report of the Expert Panel on Asylum Seekers<sup>88</sup> made recommendations regarding greater monitoring of mental health at the centres in Nauru and Papua New Guinea.

Australia's obligations under the CAT are to prevent and redress torture and ill treatment, and to guarantee that all persons deprived of liberty are 'treated with humanity and with respect for the inherent dignity of the human person'<sup>135</sup>. Given that the definition of torture that appears in article 1(1) of the CAT covers acts that inflict suffering on a person's mental wellbeing, this section focuses on the obligations established in the CAT that are indirectly linked to the policy area of health care. These obligations include that:

- Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture.
- The prohibition against torture shall be absolute and upheld also in other exceptional circumstances (article 2).
- No State Party may expel or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture (article 3).
- Each State Party shall keep under systematic review interrogation rules, instructions, methods and practices as well as arrangements for the custody and treatment of persons subjected to any form of detention, with a view to preventing any cases of torture (article 11).
- Each State Party shall ensure that an individual who alleges that he has been subjected to torture will have his case examined by the competent authorities (article 13).
- Each State Party shall ensure to victims of torture an enforceable right to fair and adequate compensation (article 14).

## Convention on the Rights of the Child

The *Convention on the Rights of the Child* (CRC)<sup>137</sup> came into force on 2 September 1990 and Australia was one of the first countries to become a party to it. The Australian Government ratified the CRC in December 1990 and it became binding in January 1991. The *Optional Protocol on the Involvement of Children in Armed Conflict* entered into force on 12 February 2002, and was ratified by Australia on 26 September 2006<sup>138</sup>.

The implementation of the CRC and its Optional Protocols is monitored by the UN Committee on the Rights of the Child, to which Australia submits regular reports.

The four core principles of the CRC are non-discrimination; devotion to the best interests of the child; the right to life, survival and development; and respect for the views of the child.

Australia's obligations under the CRC in relation to children who are seeking asylum, in detention or involved in armed conflict are as follows:

- States Parties are to provide protection and care to ensure the wellbeing of children, taking into account the rights and duties of their parents and ensuring in the absence of parents that the institutions, services and facilities responsible for their care shall conform with the standards established by competent authorities in the areas of safety and health (article 3).
- The right to protect the child from all forms of physical or mental violence and abuse, and the responsibility of the State to take all appropriate legislative, administrative, social and educational measures to ensure that (article 19).
- The right to receive appropriate protection and humanitarian assistance when seeking refugee status and the right to trace the parents or other members of the family for reunification (article 22).
- The right to enjoy the highest attainable standard of health and the right of access to health care services (article 24).
- The right to ensure that no child shall be detained or deprived of his or her liberty and those deprived of liberty shall be treated with humanity and respect in a manner which takes into account the needs of his or her age. The detention of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time. Every child has the right to maintain contact with his or her family through correspondence and visits (article 37).
- The right to ensure protection and care of children who are affected by an armed conflict (article 38).
- The responsibility of the State to take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: abuse, torture or any other form of cruel, inhuman or degrading treatment or punishment, or armed conflict (article 39) (UN General Assembly CRC 1989).



**Table 7: Outline of relevant UN Human Rights Conventions**

UN HUMAN RIGHTS TREATIES	ABBREVIATION	STATUS	DESCRIPTION OF RELEVANT OBLIGATIONS
United Nations Convention relating to the Status of Refugees	The Refugee Convention or CRSR	Signed and Ratified	The 1951 Convention, together with the 1967 Protocol is the most widely ratified refugee treaty that identifies the essential characteristics of the refugee, and outlines a number of obligations which are crucial to achieving the goal of protection.
The International Covenant on Economic, Social and Cultural Rights	ICESCR	Signed and Ratified	This covenant describes the basic economic, social, and cultural rights of individuals and nations, including the right to: <ul style="list-style-type: none"> <li>• earn sufficient wages to support a minimum standard of living</li> <li>• enjoy equal pay for equal work</li> <li>• equal opportunity for advancement</li> <li>• accessible health care</li> <li>• accessible education at all levels.</li> </ul>
The International Covenant on Civil and Political Rights	ICCPR	Signed and Ratified	This covenant details basic civil and political rights of individuals and sets conditions whereby everyone may enjoy these rights including: <ul style="list-style-type: none"> <li>• the right not to be deprived of their means of subsistence</li> <li>• the right to legal recourse when rights have been violated, even if the violator was acting in an official capacity</li> <li>• the right to freedom of movement and to choose one's residence.</li> </ul>
International Convention on the Elimination of All Forms of Racial Discrimination	ICERD	Signed and Ratified	The Convention guarantees the rights of all individuals and prohibits discrimination based on race, colour, descent or ethnic or national origin, or language.
The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	The Convention against Torture, or CAT	Signed and Ratified	This convention bans torture under all circumstances and establishes that states to take effective legal and other measures to prevent it. The CAT also forbids: <ul style="list-style-type: none"> <li>• activities which do not rise to the level of torture, but which constitute cruel or degrading treatment or that inflict suffering on a person's mental wellbeing</li> <li>• refoulement of individuals to a country where they are at risk of persecution or danger.</li> </ul> The CAT requires each state to investigate official complaints made by individuals who allege that someone has committed torture against them and, provide compensation if the complaint is proven, including full medical treatment and payments to survivors if the victim dies as a result of torture.
The Convention on the Rights of the Child	CRC	Signed and Ratified	This convention provides for special safeguards and care appropriate to minors, including appropriate legal protection relating to the welfare of children.

# Challenges and human rights violations experienced by asylum seekers in Australia

To explore Australia's core obligations, the following section examines whether the conventions discussed above bear directly upon the right to access health care, adequate housing and income support/employment for asylum seekers.

## Direct Links to Health Care

Article 12 of the ICESCR establishes 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'<sup>129</sup>. Paragraph (e, iv) of article 5 of the ICERD specifically guarantees the right of everyone to public health and medical care, without any form of discrimination<sup>133</sup>. Accordingly, the right to health does not mean the right to be healthy, but rather taking into account the World Health Organization's definition of health as '*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*'<sup>139</sup>. As a full member of the ICERD, Australia has an obligation to guarantee the realisation of this right, without any form of discrimination.

As stated by the Committee on Economic, Social and Cultural Rights (CESCR)<sup>4</sup>, the right to health is an inclusive right with core obligations that must be fulfilled. This right encompasses the individual's biological and socio-economic preconditions, and must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions in order to achieve the highest attainable standard of health<sup>140</sup>.

As listed in the ICESCR, some of the steps to be applied by the States Parties to achieve the full realisation of this right include the provision of access to medical care for all; the prevention, treatment and control of disease; and ensuring the healthy development of children. These steps include references to elements such as accessibility, acceptability and quality<sup>140</sup>.

The element of 'accessibility' signifies that health care facilities, goods and services must be accessible for all sections of the population without discrimination. This includes physical and economic accessibility whereby health services must be within safe and physical reach for all and affordable to all. Health-related information and ideas concerning health issues must be accessible when required. Accessibility also applies to children as indicated in article 24 of the CRC, which specifies that children have the right to enjoy and access the highest attainable standard of health and health care services for the treatment of illness and rehabilitation of health.

In relation to 'acceptability', the CESCR specifies that States Parties must ensure that all health facilities, goods and services abide by certain medical ethical standards and are culturally appropriate. And 'quality' refers to the provision of timely, appropriate and high-quality medical services.

In considering non-citizens, under which asylum seekers fall, the Committee on the Elimination of Racial Discrimination stresses the obligation of States Parties to recognise the right of non-citizens to an adequate standard of physical and mental health and the removal of barriers that prevent them from enjoying the right to good health<sup>141</sup>.

Additionally, there are rights afforded to non-citizens that prohibit acts that inflict mental harm on them. The CAT equates acts that inflict suffering on a person's mental wellbeing with 'torture'. Additionally, article 7 of the ICCPR stipulates that everyone has the right to freedom from degrading treatment; and articles 3 and 4 of the CAT prohibit torture and non-refoulement to another State where there are substantial grounds for believing that asylum seekers would be in danger of being subjected to torture.

In Australia not all asylum seekers are eligible for Medicare (see section 5). Provision of health services to Medicare-ineligible asylum seekers is facilitated in some States but with limitations. There is an absence of a

<sup>4</sup> The CESCR was established by the UN Economic and Social Council (ECOSOC) to carry out the monitoring functions that had been assigned to ECOSOC.

universal policy that allows asylum seekers access public hospitals across all states, despite their experiences of financial hardship due to having little or no income. These limitations pose serious concerns for asylum seekers, given the pressures put on them during the asylum determination process and the meagre resources afforded to them to manage everyday health emergencies rather than focus on self-actualisation. Limitations around access to health care are explored in more detail in sections 2 and 5.

Australia is required to respect these obligations by refraining from interfering with the enjoyment of the right to health, and is required to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to achieve for all of its citizens and non-citizens in its care the full realisation of the right to health<sup>142</sup>.

## Impact of Immigration detention on health and wellbeing

Asylum seekers arriving by boat are still detained for a period of time upon arrival, in accordance with Australia's policy of mandatory detention 'for management of health, identity and security risks to the community'<sup>143</sup>. The AHRC has expressed concerns about:

- the incidence and impact of prolonged and indeterminate detention
- the use of dilapidated detention centres for accommodation
- children in detention, and the separation of families<sup>143</sup>

The Commission has also noted that the state of uncertainty experienced by asylum seekers as to when they will be released or whether they will be allowed to stay in Australia has a detrimental effect on their mental health<sup>43</sup>.

The UN Committee against Torture has noted with concern that torture is likely to occur in environments similar to those in Australian immigration detention given the prison-like atmosphere of detention and its disturbing effects. Practices in immigration detention which appeared arbitrary, and in some instances cruel and inhumane include criminalising and punitive practices, solitary confinement of detainees, instances of disregard for due process, mistreatment by officers, and a dehumanising detention environment<sup>144</sup>.

A 2009 study that measures the health impact of human rights violations related to Australian asylum policies and practices has indicated that psychological damage can occur as a consequence of being detained over long periods regardless of any previous disposition<sup>145</sup>, which is further detailed in section 2. The nature of these adverse psychological effects can compromise the capacity of asylum seekers, once released from detention and afforded permanent protection, to access timely, culturally appropriate and high-quality medical services. Therefore, the use of mandatory detention raises concerns in relation to article 7 of the ICCPR, and articles 3 and 4 of the CAT.

A submission to the Australian Parliament's Joint Select Committee on Australia's Immigration Detention Network highlights the direct link between the harm experienced by asylum seekers when detained and its long term impact post detention<sup>143</sup>:

*"the enduring nature of these adverse psychological effects can be understood in terms of changes to core belief systems affecting views of the self and relationships, and values about justice and humanity."* (p.438)

The damage to asylum seekers' sense of self may be irrevocable, and is a consequence of the degrading treatment of detention. While article 7 of the ICCPR (the right to not subject anyone to cruel, inhuman or degrading treatment) and articles 3 and 4 of the CAT (prohibitions against torture) are not directly linked to health, the obligations contained therein need to be fulfilled to ensure the realisation of health-related human rights.

## Children Seeking Asylum

There are special protection measures in the CRC with regards to the health of children seeking asylum. Articles 3 and 19 of the CRC require that States Parties not only ensure that institutions, services and facilities responsible for the protection of children conform with the standards established by competent authorities in the area of health, but also take all appropriate legislative, administrative, social and educational measures to ensure that children are protected from mental violence and abuse. Article 39 of the CRC extends these measures to promote the physical and psychological recovery and social reintegration of a child victim of torture or any other form of cruel, inhuman or degrading treatment or punishment.

In the circumstances of unaccompanied minors, being separated from family is detrimental to the health and wellbeing of the child. Australia is in breach of the right to family reunification as established in article 22 and 37 of the CRC, as current immigration policies create impediments to the child's ability to reunite with their family. While the guardian role for these children sits with the Minister of Immigration, this has been widely criticised because he has an inherent conflict of interest and cannot act in the children's best interest due to his role in implementing tough policies around border protection, detention and onshore/offshore processing. Indeed the 2012 report of the Joint Select Committee on Australia's Immigration Detention Network found at 5.9559:

*“The Committee notes community concern regarding the guardianship of unaccompanied minors, and recognises the potential for a conflict of interest to arise where the Minister is simultaneously responsible for detaining asylum seekers for the purposes of processing their claims and acting in the best interest of unaccompanied minors seeking asylum. The Committee is of the view that the legal guardianship of unaccompanied minors in immigration detention should be transferred from the Minister for Immigration as soon as practicable.”*

The fulfilment of the right to health without any form of discrimination is linked to the actualisation of other health-related human rights. Such health-related rights, which are enshrined in the ICERD, include the right to housing and work without any form of discrimination (article 5)<sup>140</sup>. These rights will be expanded on in the sections below.

## Direct Links to Housing

Housing is a fundamental human right, according to a number of human rights treaties to which Australia is party. Article 11 of the ICESCR recognises the right of everyone to an adequate standard of living for him/herself and his/her family, including adequate housing<sup>129</sup>. Housing is also contained as a right in the provisions of some other conventions, including articles 21 and 26 of the Refugee Convention, article 12 of the ICCPR and article 5 of the ICERD, which stipulate that everyone has the right to housing and to choose his/her residence. Despite an absence of public policy debate around the housing needs of asylum seekers in Australia, in 2002 the Australian Government endorsed the conclusions of the Executive Committee of the UN High Commissioner for Refugees, which stated that<sup>146</sup>:

*“Asylum seekers should have access to the appropriate governmental and non-governmental entities when they require assistance so that their basic support needs, including food, clothing, accommodation, and medical care are met.”*

However, in Australia there is no legislative framework within which to mandate the provision of housing to asylum seekers outside the community detention system and no legislative urgency to facilitate their access to government-funded housing programs<sup>42</sup>. This is inconsistent with Australia's human rights obligations as it breaches article 11 of the ICESCR, article 12 of the ICCPR, article 5 of the ICERD and articles 21 and 26 of the Refugee Convention.

To avoid destitution of asylum seekers in the community and aid their integration, Australia has a responsibility under various international treaties to protect rights (linked to the policy areas examined) in its domestic legal system and constitution.

## Direct Links to Income Support/Employment

The arrangements for asylum seekers living in Australia in relation to access to health services, accommodation and entitlements vary depending on their visa status (see section 5). Yet all asylum seekers confront significant barriers to workforce participation and experience severe financial hardship (see section 1).

In considering the conventions listed above, there are three articles in the ICESCR that are directly linked to the right to work. Under article 11, everyone has the right to an adequate standard of living. This is reiterated in article 6, as the ICESCR establishes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts, and will take appropriate steps to safeguard this right. Following article 7, the ICESCR recognises ‘the right of everyone to the enjoyment of just and favourable conditions of work’ which ensure fair wages and equal remuneration for work without distinction; a decent living; safe and healthy working conditions; equal opportunity and promotion; and reasonable limitation of working hours<sup>129</sup>.

Other human rights contained in the ICESCR which are indirectly linked to the right to employment include ‘the right of everyone to social security’ (article 9). Engaging in wage earning employment and/or self-employment, as well as accessing public assistance and social security are also contained as rights in articles 17, 18, 23 and 24 of the Refugee Convention. The right to work, to have a choice of employment, to just and favourable conditions of work, to protection against unemployment, to equal pay for equal work, and to just and favourable remuneration are also recognised in article 5 (e, i) of the ICERD, in which everyone must be able to enjoy this right without any form of discrimination.

Restrictions on work rights (see section 5) and barriers to finding employment (see section 1) imposed on asylum seekers is in violation of article 6 of the ICESCR, which stipulates that, in order to achieve the full realisation of the right to work, States Parties must provide ‘technical and vocational guidance and training programmes, policies and techniques to achieve...full and productive employment’<sup>129</sup>. Such restrictions are also in breach of articles 17, 18, 23 and 24 of the Refugee Convention. Restricting these rights denies access to basic services, which in turn negatively impacts one’s mental health and wellbeing.

Thus, the right to work should be extended to all adult asylum seekers including those arriving by boat post August 13, 2012 (who are currently subject to work restrictions based on the ‘no advantage’ principle) and those placed in community detention. As the Australian Treasury’s InterGenerational Report<sup>147</sup> noted:

*“well-being is enhanced if ... members of society have the opportunity to participate in economic and social activities. Education, quality health services and access to employment, for instance, contribute to higher productivity growth and higher labour force participation.”*<sup>(p.83)</sup>

The AHRC states that ‘without the ability to support themselves through work or social security, asylum seekers are entirely dependent on community services for their basic subsistence’<sup>143 (p.201)</sup>. Due to the challenges they face in securing an income, asylum seekers are often unable to provide themselves with adequate and secure accommodation and nutrition. Some take desperate measures and work in unsafe environments where they are likely to be exploited by employers. This scenario means the Australian Government is in breach of the right to health (article 12) and the right to work (articles 6 and 7) as the ICESCR highlights health concerns in provisions related to unsafe work conditions and harmful exploitative labour.

While Australia signed and in some instances ratified UN conventions, these covenants have never been comprehensively incorporated into Australian domestic law. As a result, there is an absence of judicial, administrative or legislative authorities to remedy any of the violations identified above as any concluding observations made by UN committees lack any binding legal force in Australia<sup>148</sup>.

# Policy implications for Australia for seeking greater alignment with UN obligations

To bring Australia more fully into compliance with its obligations under the UN Conventions mentioned earlier in this section, a range of policy changes are required to ensure that all asylum seekers, irrespective of their visa status, have access to the essential services required for an adequate standard of living such as medical services and treatment, substantial nutrition, clothing, bedding and an adequate and secure home. The duty of care should lie with the Australian government, rather than the asylum seeker and charitable sector. These changes include:

## Policy Area of Health

- Legislatively provide for an end to mandatory detention, bringing Australia in line with its international obligations not to unnecessarily detain, punish or torture asylum seekers. This particularly relates to the policy area of mental health.
- Incorporate reference to acts of torture included in the CAT Convention into relevant federal laws relating to the treatment of asylum seekers, in particular those that inflict suffering on a person's mental wellbeing such as detention.
- Heed the consequences of long-term detention, particularly in relation to mental health.
- Ensure that reparative justice acknowledge the treatment and active support required by asylum seekers to promote their recovery<sup>81</sup> and resource the health care system to meet their long term needs including as a result of detention.
- Ensure that asylum seekers' access to health care is met to the same level as the general population.
- Legislatively provide all asylum seekers with universal access to Medicare and Health Care Cards.

## Policy Area of Housing

- Provide housing and housing support to asylum seekers within the current federal and state legislative frameworks, taking into consideration current asylum seeker entitlements and human rights<sup>42</sup>.
- Put in place a legislative framework governing housing for asylum seekers during their status resolution process to enhance access to safe and secure housing.
- Provide safe, secure and subsidised housing consistent with the current Australian humanitarian and protection framework, where housing is one component of a range of supports within the status resolution process<sup>42</sup>.
- Amend the *Supported Accommodation Assistance Act 1994* to enshrine a right of access to crisis accommodation for homeless asylum seekers where government funded Community Assistance and Support Scheme (CAS) is expanded to include all asylum seekers at risk of homelessness<sup>42</sup>.
- Improve access to various forms of supported housing and accommodation, particularly housing which meets the needs of people experiencing mental illness.
- Include the provision of safe and secure housing for vulnerable community-based asylum seekers and humanitarian appellants in the Federal government's strategic agenda for reducing homelessness in Australia by 2020.



## Policy Area of Income Support/Employment

- Provide a model of early intervention and prevention that would see all asylum seekers having access to an income safety net such as the Asylum Seeker Assistance Scheme. This guarantees a level of income support sufficient to meet basic needs for those who are unable to generate an independent income<sup>15,143</sup>.
- Extend work rights to all asylum seekers during the asylum determination process regardless of how and when they entered Australia.
- Provide appropriate services for asylum seekers living in the community to ensure they can attain an adequate standard of living.
- Improve the work readiness of asylum seekers by putting in place specific measures to widen their participation and enable them to improve their long-term employability and thereby self-reliance.
- Test new ways of fast tracking asylum seekers into supported work-placement and employment programs, allocate funding for traineeships and create greater opportunities for volunteer work to gain experience. Increase access to English language programs provided by teachers from a similar language background as the asylum seekers<sup>149</sup>.

## Policies in relation to children

Ensure that Australia's migration and asylum legislation and procedures have the best interests of the child as the primary consideration in all asylum processes.

Remove the Minister for Immigration from being deemed the legal guardian of unaccompanied minor asylum seekers and thereby remove the Minister's conflict of interest and protect the best interests of the child.

Ensure that determinations of the best interests of the child are consistently conducted by professionals who have been adequately trained in best interest determination procedures<sup>150</sup>.

Consider enacting a comprehensive child rights Act at a national level, which fully incorporates the provisions of the Convention of the Child and Optional Protocols and provides clear guidelines for their consistent and direct application.

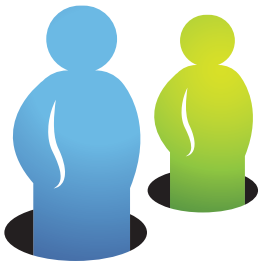
Take measures to maintain the unity of the family and reunite family members who have been separated.

Pay particular attention to ensuring that Australia's policies and procedures in relation to asylum seeker children, refugee children and children living in immigration detention give due primacy to the principle of the best interest of the child. This would include legislative changes to end mandatory detention of children and their parents.

## Policies for State Governments

- Replicate the Victorian Government's funding contribution to key asylum seeker agencies (Victorian Office of Multicultural Affairs and Citizenship) to ensure state of residency does not impact support available to asylum seekers. While it is arguable that is not the role of the states to fund asylum seeker support and is the role of the Federal Government, the Victorian (then Labor) Government stepped in to meet gaps and reduce poverty and disadvantage suffered by asylum seekers living in Victoria.





## Section 5:

# Overview of Australia's legislation and policies regarding asylum seekers

## Summary section 5

A person can apply for a protection visa in Australia through the 'offshore' or 'onshore' components of the Refugee and Humanitarian Program. In the financial year 2011-2012, Australia's Refugee and Humanitarian Program resulted in the placement of 13,759 people. This scoping study is primarily concerned with 'onshore' asylum seekers.

Asylum seekers arriving by boat are referred to by DIAC as "Irregular Maritime Arrivals" (IMAs). They usually arrive without valid documentation and are taken to Christmas Island for processing. Sometimes detainees will be transferred to an Immigration Detention Centre or other detention program on Australia's mainland. Families, unaccompanied minors and vulnerable adults may be transferred into a supportive Community Detention program. Independent bodies have raised concerns about the environment of detention centres and the provision of adequate health care for detainees. The physical and mental health status of asylum seekers in detention will inevitably impact on community services when asylum seekers are released – as reflected in recent policy changes. Since late 2011, large numbers of asylum seekers have been released into the community on bridging visas. Of this group, those arriving pre-August 13, 2012 generally have work rights, while those arriving after this date currently do not.

Asylum seekers arriving by plane usually enter Australia with a valid visa, such as a student or tourist visa before seeking protection. They are generally not subject to immigration detention. Bridging visas allow asylum seekers to live lawfully in the community while they wait for a decision on their visa application. Most bridging visas granted to asylum seekers arriving by plane allow them to work, which also means they have access to Medicare. Policy around bridging visas and permission to work is complex, and is dependent on DIAC operational and also some discretionary policy.

Organisations in each state are contracted by DIAC to facilitate support programs for asylum seekers in the community, regardless of mode of arrival. However, the financial support is limited and most asylum seekers struggle to make ends meet. Asylum seekers that are not eligible for these programs are at even higher risk of homelessness and destitution due to difficulties finding employment (if permitted to work).

Asylum seekers with Medicare can access the same health services as an Australian citizen. Asylum seekers without Medicare cannot afford to pay medical expenses so must rely on the generosity of individuals willing to provide pro-bono services. Some states have recognised these inequities and developed fee-waiver policies for public hospital services, which assists significantly, but does not address all their needs. Asylum seekers are disadvantaged due to their ineligibility for a Health Care Card and some difficulties accessing the PBS.

Policy pertaining to asylum seekers can change rapidly, which requires immense adaptability by the community and welfare sector. There remain many policy areas that could be addressed to improve the health and wellbeing of asylum seekers. Due to the no-advantage principle that came out of the Report of the Expert Panel on Asylum Seekers, it is unclear what the future holds for many asylum seekers arriving by boat. The vast majority of asylum seekers will be found to be refugees. While awaiting a decision, asylum seekers in the community should be granted the same privileges as Australian citizens, but this remains to be seen.

# Introduction

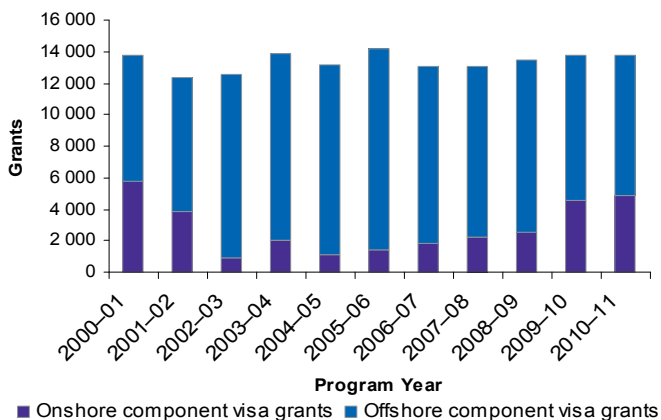
Section 5 provides an overview of the Commonwealth policy relating to asylum seekers that seek protection ‘onshore’ in Australia. It seeks to inform the reader about: Australia’s Refugee and Humanitarian program; make comparisons between asylum seekers arriving by plane or boat; the visa application process and avenues of appeal; Australia’s immigration detention policy and programs; the provision of health care in detention; bridging visas and entitlements to support and health services while awaiting a decision in the community. There has been considerable media attention on asylum seekers recently due to increased boat arrivals and the subsequent release of the Report of the Expert Panel on Asylum Seekers. Although policy related to offshore processing is not the focus of this section, some brief information will be provided for the interest of the reader. This information was gathered in September 2012, however on release of the report, every effort was made to update the information in line with relevant policy changes. Where possible, the most up-to-date, publicly-available statistics are provided on the asylum seeker population. Policy around asylum seekers can evolve quickly and services need to be flexible to respond to the changing needs of the population. Inevitably, to improve equity of access and more sustainable solutions for asylum seekers, organisations need to advocate for policy and legislative change.

## Overview of Australia’s refugee and humanitarian program

The Office of the United Nations High Commissioner for Refugees (UNHCR) estimates that at the end of 2011, there were 42.5 million forcibly displaced people worldwide. This includes around 26.4 million internally displaced persons (IDPs), 15.2 million refugees and 895 000 asylum seekers<sup>52</sup>. In the financial year 2011-2012, Australia’s Refugee and Humanitarian Program resulted in the placement of 13,799 people<sup>151</sup>.

A person can apply for a protection visa in Australia through the ‘offshore’ or ‘onshore’ components of the Refugee and Humanitarian Program. In August 2012, the Australian government announced the number of settlement places would increase to 20,000, with an additional 4,000 family reunion places. This includes 12,000 places for those accepted through the Refugee component of the offshore program, including 1,000 UNHCR-referred refugees from Malaysia; and 8,000 places to be shared between the onshore program and the Special Humanitarian Program (SHP) stream of the offshore program<sup>152</sup>. The linking of these two programs means that if greater numbers of visas are granted to onshore applicants, fewer SHP applicants will be accepted (Figure 1).

**Figure 1: Number of visas granted through the Humanitarian program: 2000-2011**



Source: DIAC 2011<sup>151</sup>

## Offshore program

In 2011-12, 6718 visas were granted through the offshore component of the Refugee and Humanitarian program, accounting for 49% of all protection visas granted<sup>153</sup>. Offshore visa applicants are not in Australian territory, may be living in temporary refugee camps, and can be referred to Australia by the UNHCR or by Australian family sponsorship or other organisations and sponsorships. People can be granted a permanent visa in Australia under the offshore component of Australia's program through a number of visa types, provided they pass health, security and character checks. Part of this cohort are supported during the resettlement period in Australia with the Humanitarian Settlement Services (HSS) program, which assists refugees to integrate into their community, including assistance finding housing, schools and general orientation<sup>154</sup>. People arriving to Australia through the offshore program are not of interest for the purpose of this report because once the visa has been granted, they are no longer considered asylum seekers and they receive full benefits and entitlements

## Onshore program

In 2011-12, 7,041 visas were granted through the onshore component of the refugee and humanitarian settlement program, accounting for 51% of all protection visas granted<sup>153</sup>. For the purpose of this report, all people seeking asylum through the onshore program are of interest. There are two ways that people may seek asylum 'onshore':

### Boat arrivals: "IMAs"

Asylum seekers may arrive in Australia without a substantive (valid) visa (such as a student, tourist or business visa) and then apply for a protection visa (subclass 866). This group are sometimes referred to by the DIAC as "Irregular Maritime Arrivals" or IMAs because they usually arrive by boat. Other countries in our region which often serve as transit points - such as Malaysia and Indonesia - are not signatories to the Refugees Convention<sup>122</sup>. Asylum seekers may wait for many years in these countries after registering with the UNHCR to be recognised as a refugee. They usually have no rights, including no access to work, schooling for their children, and are at risk of abuse, exploitation and imprisonment. For reasons such as this, some asylum seekers feel they have no choice but to take a dangerous journey to Australia by boat. Because they have entered Australia without a visa, they may be considered 'unlawful' by the Australian government and placed in a mandatory detention centre. Generally they are placed in detention on Christmas Island before being moved to mainland detention programs or may be released into the community (as explained in greater detail later in this section). On August 17 2012, legislative changes were made by the Australian Parliament to the Migration Act to enable offshore entry person to be taken to another country for assessment and processing of their refugee claims. In September and October 2012, documents were tabled in Parliament outlining Nauru, and Manus Island Papua New Guinea as regional processing centres. It is currently unclear how long IMAs may be waiting in these offshore processing centres.

- In the financial year 2011-12, 7379 refugee status determination requests were received from IMAs<sup>155</sup>

### Plane arrivals: "non-IMAs"

Alternatively, asylum seekers may arrive *with* a substantive visa, usually by plane, and then apply for a protection visa. This group are sometimes referred to as non-IMAs. Asylum seekers arriving with a valid visa are considered 'lawful' provided they adhere to the conditions of the visa that they arrived with, or an alternate visa is granted. Unlike IMAs, this group are generally not subject to immigration detention and are permitted to live in the community while they wait for their visa application to be processed. A small number of asylum

seekers who arrive by plane do so 'unlawfully' by arriving with a false passport or invalid visa. In the financial year 2010-11 only 27 people were in this category<sup>156</sup>. There are also a small number of people who may arrive by boat lawfully (for example ship stowaways or crew) and then apply for a protection visa.

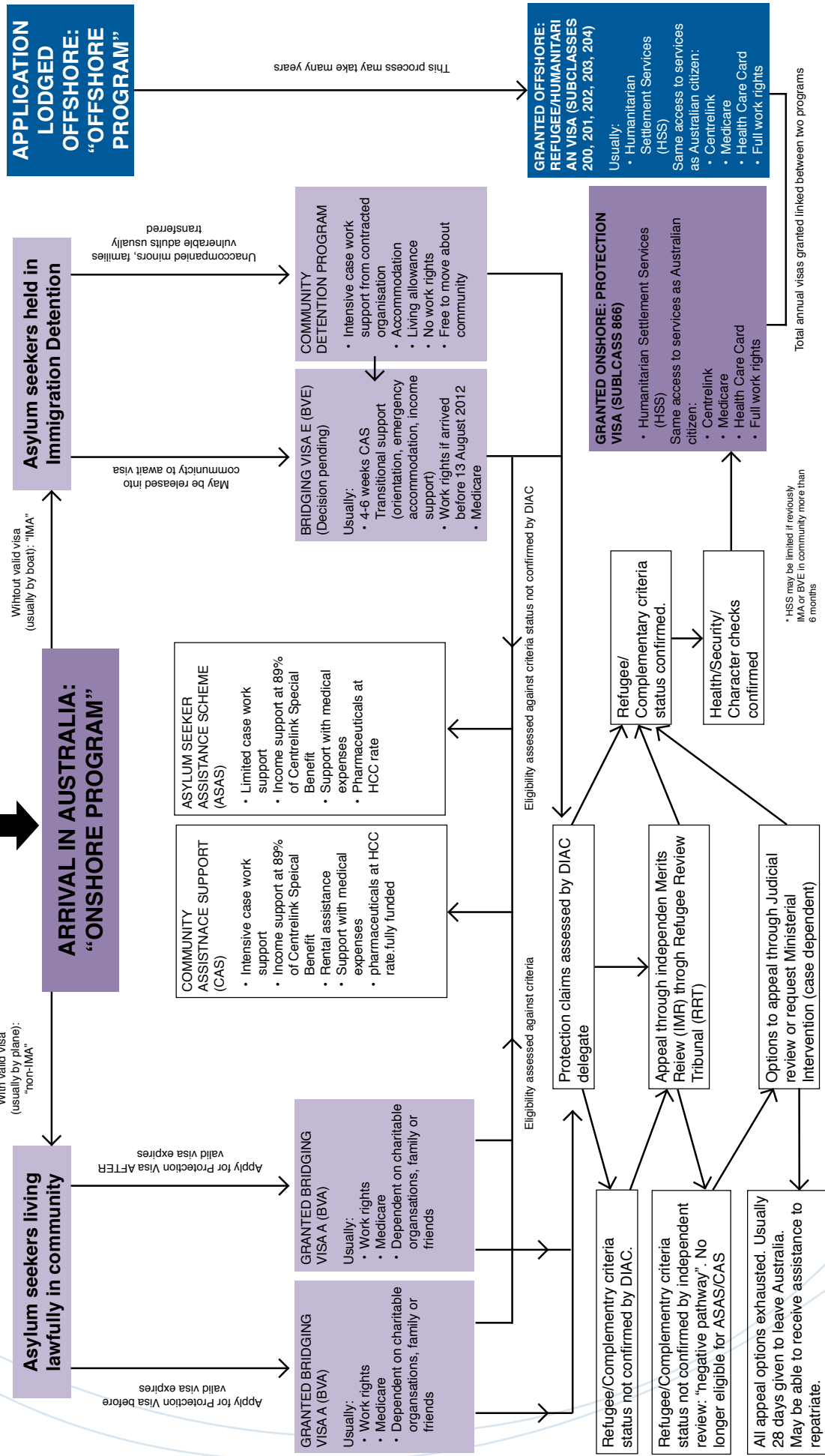
- In the financial year 2011-12, 7036 applications were submitted for protection visas by asylum seekers who had arrived by plane<sup>155</sup>
- This was an 11% increase from the previous 12 months

## Report of the Expert Panel on Asylum Seekers

The number of protection visas sought by onshore asylum seekers have risen dramatically in recent years, with just under 8000 arriving by boat alone in 2011-12<sup>157</sup>. There are many reasons why people seek refuge from persecution in their country including ethnic conflict, war and human rights abuses but these 'push factors' are outside the scope of this report. However, as a result of such factors, Australian detention centres have become increasingly crowded and several hundred people have tragically died when boats sank during the voyage to Australia. Recently, there has been significant debate in the media and on the parliamentary stage around the best legislative solution to control the number of people seeking asylum by boat. To assist the decision-making process, an expert panel was appointed including: Angus Houston (Air Chief Marshall); Michael L'Estrange (former head of the Department of Foreign Affairs and Trade); and Paris Aristotle (Director of the Victorian Foundation of Survivors of Torture). A report was released in August 2012, which can be accessed online<sup>88</sup>, with 22 recommendations on policy options to prevent asylum seekers from taking dangerous boat journeys to Australia. The Australian Labor Party has accepted in-principle all of the recommendations. To date, only some of these have been legislated or enacted. The merit of the Report of the Expert Panel on Asylum Seekers is being discussed in many academic and political forums. An analysis of these recommendation is outside the scope of this study; for further information the Refugee Council of Australia have released their own comprehensive analysis of the recommendations, which can be viewed on their website.

It is not yet clear what the implications of the recommendations and recent policy changes will be. The future impact of these policy changes are likely to affect the number of asylum seekers living in Australian communities, as well as their health needs and access to services. Organisations involved in providing services to asylum seekers are inevitably affected by such changes and must be willing and able to respond swiftly to the changing needs of the population.

Figure 2 The process of seeking asylum in Australia



# Application process

In order to be granted a protection visa, onshore asylum seekers, both in the community and in detention, must have their refugee claims assessed. If their initial claims are rejected (that is; they do not meet the refugee or complementary criteria outlined in section 4), they can pursue other avenues as described here. Most asylum seekers, if rejected, will appeal all avenues available to them. A person may move between these stages and this can have an enormous impact on their mental state due to uncertainty and anxiety about the visa process. It is difficult to determine how long people spend waiting for a decision at each stage. It has been reported that there are people living in the community and in detention programs who have been waiting for many years on an outcome of their visa application.

Asylum seekers face a number of challenges during the interview process and there are a variety of factors which may affect the decision on their visa outcome. For example, inconsistencies in a person's story (which can be affected by poor mental health, use of language or misunderstanding about the refugee determination process) may be incorrectly seen to reflect disingenuous claims<sup>158</sup>. Asylum seekers have a right to interpreters for all visa processes and most can also access free professional migration advice through the government-funded Immigration Advice and Application Assistance Scheme (IAAAS).

## Boat arrivals/ IMAs

Application for a protection visa through the onshore program differs for asylum seekers depending on their means of arrival. Since September 2001, legislation has been amended so that tracts of Australia's northern territorial waters and islands have been declared 'offshore excised places'<sup>159</sup>. Although they are still under Australian jurisdiction and sovereignty, anyone who first enters Australia at an offshore excised place (by boat) without a valid visa can be detained and barred from applying for a protection visa. The Minister for Immigration and Citizenship has the discretionary power to make allowances for such applications if it is believed to be in the public's best interest to do so. Since March 2012, a new single process for IMAs means that their application is brought into line with that of non-IMAs<sup>160</sup>. IMAs now attend an entry interview and if the person has refugee claims to assess, the Minister 'lifts the bar' to allow them to apply for a protection visa.

## Plane arrivals/non-IMAs

By comparison, there is no bar on asylum seekers applying for a protection visa after arriving by air with a valid visa because they have arrived in Australia's migration zone. Sometimes a person may apply immediately after arrival in Australia by plane. On other occasions, the political situation in a person's country of origin may change, resulting in them seeking protection later. Due to the complexity of the visa process, asylum seekers may miss the time limits or attendance requirements at various stages of the process<sup>158</sup>. This may impact their eligibility for work rights and other services. The application process described below now applies to all asylum seekers, regardless of their mode of arrival.

## Primary stage

A protection visa applicant will be required to submit the correct paperwork and provide biometric information. Their eligibility for a bridging visa (which allows them to remain lawful in the community) will be assessed and they will be required to undergo health and character checks, as well as security checks in some cases. If certain health conditions are identified, such as dormant tuberculosis or suspected infections, the asylum seeker may be required to report to appropriate health authorities in order to follow up the condition in the community. It will not affect their visa outcome. A delegate from DIAC will review the protection visa application, including assessment of the individual's refugee claims. The applicant is invited to attend an interview with the delegate and decision should be made within 90 days. Further information may be



requested at any stage of the process. In the financial year 2011-12, 65% of cases were seen within the 90 day time frame<sup>153</sup>.

- In 2011-12, of the 4325 non-IMA asylum seekers refused at the primary stage, 90% decided to appeal the decision through the Refugee Review Tribunal. 28% of such cases resulted in remittal back to DIAC<sup>155</sup>.

## Merits review

If the protection visa is refused at the primary stage, asylum seekers have the right to have this decision reviewed (an 'independent merits review' or IMR) by an independent tribunal: the Refugee Review Tribunal (RRT). Asylum seekers in the community must apply to the tribunal within 28 days of notification of a protection visa refusal at the primary stage or their application will be considered 'finally determined.' If the Tribunal finds reason for the Department to reconsider the visa application – for example if new information substantiates their claim or circumstances have changed in their country of origin - then the application will be sent back again ('remittal'). Otherwise, the asylum seeker will be required to prepare to leave the country, unless they pursue further options. A person whose protection visa application was rejected at the merits review stage is considered by DIAC to be on a 'negative pathway'. It is at this point that asylum seekers may lose access to some services, while some asylum seekers may choose to disengage with DIAC and become unlawful.

## Judicial review

Asylum seekers whose claims are rejected by an independent tribunal can appeal their case through the courts. This is only for situations where there may be an error in the legal processes followed by the tribunal. Obviously, there are considerable expenses attached to pursuing court proceedings and this option will not be recommended in most cases.

## Ministerial intervention

Under section 417 of the Migration Act 1958, the Minister for Immigration and Citizenship has the power to make a decision that is more favourable for an individual whose application has been rejected at the primary and independent review stages if he or she believes it to be in the public interest. This is usually because the individual does not satisfy the criteria for a protection visa, but there are exceptional circumstances that the individual believes should be considered.

The current number of people whose protection claims have been rejected and are awaiting a decision regarding Ministerial intervention was not able to be provided by DIAC.

## Plane arrivals/Non-IMA grant rate

In general, asylum seekers who arrive by plane are less likely to be recognised as refugees compared to those who arrive by boat. The most recent data available on grant rates for non-IMAs suggest that around one-quarter of applicants are successful in being granted a protection visa at the primary stage<sup>155</sup>. Table 8 and Table 9 demonstrate an increase in grant rates from primary stage to the final stage of the visa process. It is important to keep in mind that the number of applications lodged is not in direct relationship to the number of decisions made - the visa determination process may take many months, or even years. These figures are provided to demonstrate that many non-IMA asylum seekers will not be successful at the primary stage and will be required to pursue other avenues of appeal. This means that they are more likely to spend long periods of time in the community waiting with uncertainty about the future.

- In 2011-12, around 25% of non-IMAs were successfully granted a protection visa at the primary stage. In the same time frame, at the final stage, 44% of non-IMAs were successfully granted a visa<sup>155</sup>.

**Table 8: Number of visas granted to non-IMAs at the primary stage**

TIME FRAME	NUMBER OF DECISIONS MADE	VISAS GRANTED		VISAS REFUSED	
		Number	Percentage	Number	Percentage
2011-2012	5792	1467	25.3%	4325	74.7%
2010-2011	5494	1389	25.3%	4105	74.7%

Source: DIAC 2012<sup>155</sup>

**Table 9: Number of visas granted to non-IMAs at the final stage**

TIME FRAME	NUMBER OF DECISIONS MADE	VISAS GRANTED		VISAS REFUSED	
		Number	Percentage	Number	Percentage
2011-12	5159	2272	44.0%	2887	66%
2010-11	4840	2101	43.4%	2739	56.6%

Source: DIAC 2012<sup>155</sup>

## Boat arrivals/IMA grant rate

In general, asylum seekers that arrive by boat are more successful in being granted a protection visa. Table 10 and Table 11 show the visa grant rates by program year. Despite the high visa grant rate, a large number of asylum seekers are held for extended periods of time in detention.

- In 2011-12, 91% of asylum seekers arriving by boat, whose claims were assessed, were found to be genuine refugees

**Table 10: Number of visas granted to IMAs at the primary stage**

TIME FRAME	NUMBER OF DECISIONS MADE	VISAS GRANTED		VISAS REFUSED	
		Number	Percentage	Number	Percentage
2011-2012	3825	2721	71.1%	1104	28.9%
2010-2011	5218	2001	38.3%	3217	61.7%

Source: DIAC 2012<sup>155</sup>

**Table 11: Number of visas granted to IMAs at the final stage**

TIME FRAME	NUMBER OF DECISIONS MADE	VISAS GRANTED		VISAS REFUSED	
		Number	Percentage	Number	Percentage
2011-12	5240	4766	91.0%	474	9.0%
2010-11	2909	2719	93.5%	190	6.5%

Source: DIAC 2012<sup>55</sup>

## Immigration detention policy

*This section will be briefly discussing policy related to immigration detention. Although this population group is not of primary concern for the purpose of this report, it is important to be aware of these issues from an advocacy perspective and to ensure that asylum seekers receive appropriate treatment upon release from detention into the community.*

Increasingly, Western countries have resorted to ‘policies of deterrence’ to reduce the number of people seeking asylum in those countries<sup>78</sup>. Immigration detention policy was first introduced in 1992 and has maintained bipartisan support despite significant lobbying from community groups concerned about the rights and welfare of asylum seekers. According to the Australian government, mandatory detention is deemed a necessary policy to enable health and security checks to be undertaken; to prevent asylum seekers from absconding; and to act as a deterrent for other asylum seekers considering this route of arrival. As discussed in section 2, the detention environment, and the length of time spent incarcerated, has a direct impact on mental health outcomes. Asylum seekers released from detention into the community are likely to have suffered trauma and require specialist intervention as a result of policy impacting on immigration detention.

Australia has been criticised internationally for its harsh policies around detaining asylum seekers. In response, there have been a number of inquiries into the conditions and policy of detention centres. The Australian government have developed their own set of values to guide detention policy [Figure 3161], however they remain largely unimplemented. Recent concerns raised in the 2012 final report of the Joint Select Committee on Australia’s Immigration Detention Network (herein referred to as the Joint Select Committee report;<sup>59</sup>) focused on:

- The remoteness of detention centres, which made it difficult to recruit and maintain staff (including health workers)
- The absence of time limits on detention
- The lack of meaningful activities for detainees to engage in
- The powerlessness of detainees and their perceptions of injustice
- The number of unaccompanied minors in immigration detention facilities
- The subsequent effects of detention on mental health and community adjustment

Figure 3: The Australian government's key immigration detention values

#### The Australian government's seven key immigration detention values

- Mandatory detention is an essential component of strong border control
- To support the integrity of Australia's immigration program, three groups will be subject to mandatory detention:
  - all unauthorised arrivals, for management of health, identity and security risks to the community
  - unlawful non-citizens who present unacceptable risks to the community and
  - unlawful non-citizens who have repeatedly refused to comply with their visa conditions
- Children, including juvenile foreign fishers and, where possible, their families, will not be detained in an immigration detention centre
- Detention that is indefinite or otherwise arbitrary is not acceptable and the length and conditions of detention, including the appropriateness of both the accommodation and the services provided, would be subject to regular review
- Detention in immigration detention centres is only to be used as a last resort and for the shortest practicable time
- People in detention will be treated fairly and reasonably within the law
- Conditions of detention will ensure the inherent dignity of the human person

## Immigration detention programs

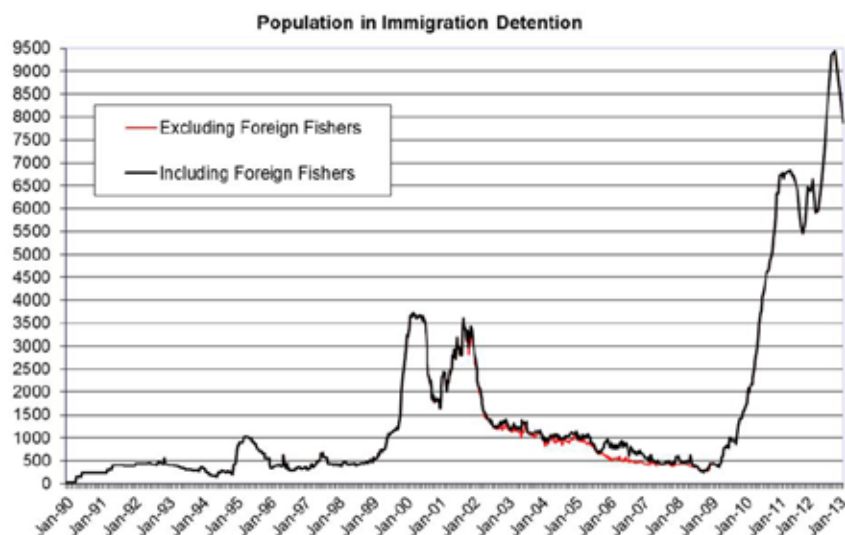
The immigration department has set up a number of programs to maintain flexibility in housing asylum seekers in immigration detention (see the map of facilities on the following page). These include:

- Immigration Reception and Processing Centres (otherwise known as immigration detention centres or IDCs)
- Immigration residential housing (IRH)
- Immigration transit accommodation (ITA)
- Alternative Places of Detention (APOD)
- Community detention

Asylum seekers may be moved from one detention arrangement to another during the time they spend waiting for an outcome on their visa process. Transfer into programs outside of IDCs is dependent on a number of factors, such as age and gender, length of time detained, vulnerability, behaviour or health status, but is at the discretion of DIAC.

As Figure 4 demonstrates, the number of people placed in immigration detention programs has increased dramatically in recent years and some facilities have become overcrowded.

**Figure 4: Number of people in Immigration Detention since January 1990**



Source: DIAC 2013<sup>162</sup>

The following are some statistics to provide an overview of the population being held in the various detention programs. As at 31 July 2012, there were 7875 people in total in all types of immigration detention<sup>162</sup>.

- 34% of this population had been detained for less than 3 months; and
- 90% of this population had been detained for less than 12 months; but
- nearly 6% of this population had been detained for more than 2 years

**Table 12: Length of time spent in detention (all programs)**

PERIOD DETAINED	TOTAL	PERCENTAGE OF TOTAL
7 days or less	154	2.0%
8 days – 31 days	327	4.2%
32 days – 91 days	2161	27.4%
92 days – 182 days	3348	42.5%
183 days – 365 days	1120	14.2%
366 days – 547 days	162	2.1%
548 days – 730 days	155	2.0%
More than 730 days	448	5.7%
<b>Total</b>	<b>7875</b>	<b>100%</b>

Source: DIAC 2013<sup>162</sup>

At present, around 95% of the population in immigration detention are IMAs. The other 5% are comprised of people who have breached visa conditions and a small number (67) who arrived by plane without valid documentation<sup>162</sup>. Asylum seekers who arrive by plane and overstay their visa or breach visa conditions are also at risk of being placed in immigration detention.

Table 13 shows a breakdown of the detention population as at January 31, 2012 by country of citizenship, gender and whether adult or child. It does not include those in Community Detention. At present, the majority (47%) of people in immigration facilities are from Sri Lanka, followed by asylum seekers from Iran, Afghanistan and Iraq. Within the ‘other’ category, there will be a number of stateless people. This can be a challenge for DIAC if they are not found to be refugees but cannot be returned to their country of origin, and results in significant distress and poor mental health outcomes for individuals with little hope of release. This is one of the reasons why a time-limit on detention is so imperative.

**Table 13: Number of people in immigration detention by country of citizenship and gender\***

COUNTRY OF CITIZENSHIP	ADULT		CHILD		TOTAL	PERCENTAGE
	Male	Female	Male	Female		
Sri Lanka	2168	186	197	112	2663	46.7%
Iran	355	172	106	91	724	12.7%
Afghanistan	445	29	135	25	634	11.1%
Iraq	112	38	41	39	230	4.0%
Bangladesh	195	0	2	0	197	3.5%
Pakistan	132	9	25	5	171	3.0%
Indonesia	103	8	7	1	119	2.1%
Myanmar	30	15	19	15	79	1.4%
China	55	18	0	0	73	1.3%
Vietnam	39	7	12	3	61	1.1%
Other	470	111	91	74	746	13.1%
<b>Total</b>	<b>4104</b>	<b>593</b>	<b>635</b>	<b>365</b>	<b>5697</b>	<b>100%</b>

\*This excludes people in community detention programs, those on Manus Island or Nauru, or Pontville detention centre

Source: DIAC 2013<sup>162</sup>

The majority of asylum seekers arriving by boat are young men. In general, this means that their physical health status is fairly good. This group are often referred to as ‘single adult males’, however in reality, many of these men have left a spouse and children back in their country of origin, or in a transit country like Malaysia or Indonesia. Asylum seekers have no family reunion rights until their protection visa is granted and so may wait many months or years to be reunited with their family. In 2011-12, around one-fifth of IMAs seeking protection in Australia were under the age of 18155. For the most part, unaccompanied minors and families

will initially be housed in alternative accommodation options, with the aim of transferring them to community detention, where possible. This transition period creates considerable concerns for their welfare as temporary accommodation options may not be appropriate for their wellbeing and development, while schooling options can be limited.

## Immigration Reception and Processing Centres

Otherwise known as IDCs, these are large detention facilities designed to accommodate ‘unlawful’ asylum seekers and other people who have breached visa conditions or arrived in Australia without valid documentation (including IMAs or illegal fishermen). The prison-like facilities are operated by the independent company Serco Australia Pty Ltd, which is contracted by the government. This company also manage immigration residential housing and transit accommodation. As of February 2013, there were eight IDCs operating on the Australian mainland and one on Christmas Island. A detention centre in Pontville, Tasmania has also been re-opened temporarily. Offshore processing centres have also recently been established on Manus Island Papua New Guinea, and Nauru. It has not yet been made clear what kinds of detention conditions or length of time spent in detention could be expected in these regional detention centres. Already there has been criticism by the UNHCR about the conditions of the regional processing centre on Nauru and the lack of clarity around the procedure of refugee status determination<sup>163</sup>.

As at July 31, 2012 there were (Table 14):

- 3465 people in IDCs including 3142 on the Australian mainland and 323 on Christmas Island
- 98.5% of all people detained in IDCs were adult males

**Table 14: Number of people in Immigration Detention Centres (IDCs)\***

STATE	LOCATION OF IDC	ADULT		CHILD	TOTAL
		Male	Female		
Excised place	Christmas Island	323	0	0	323
VIC	Maribyrnong	71	12	0	71
NSW	Villawood	340	40	0	380
QLD	Scherger	510	0	0	510
WA	Curtin	748	0	0	748
	Perth	21	0	0	21
	Yongah Hill	243	0	0	243
NT	Northern (Darwin)	279	0	0	279
	Wickham Point	878	0	0	979
<b>TOTAL</b>		<b>3413</b>	<b>52</b>	<b>0</b>	<b>3465</b>

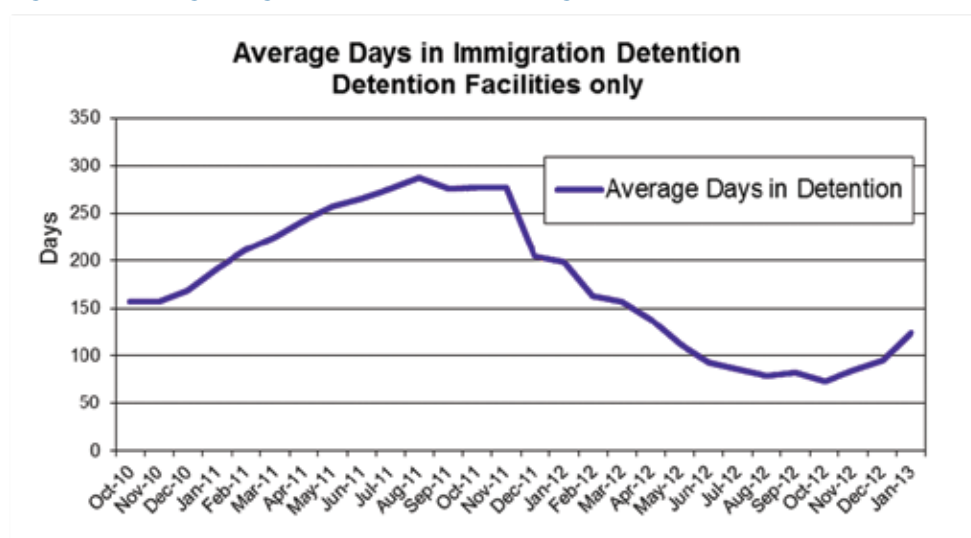
\*This does not account for those on Manus Island or Nauru, or Pontville detention centre

Source: DIAC 2013<sup>162</sup>

On average, people in IDCs have been held for 124 days<sup>162</sup>. The average length of time spent in immigration detention centres has decreased over the last 12 years. This is despite the significantly increased number of IMAs, because alternative detention programs have been established and children and families have been moved out of these environments. Many advocates in the community sector have welcomed the recent changes to release more IMAs into the community with bridging visas. However, as demonstrated in Table 15, there are still a significant proportion of asylum seekers who wait in other detention programs with anxiety about their future and unable to begin integrating into the community.



Figure 5: Average length of time spent in Immigration Detention Centres



Source: DIAC 2013<sup>162</sup>

## Alternative detention programs

Where appropriate, detainees may be housed in Immigration residential housing (IRH) or Immigration Transit Accommodation (ITA). These options may be considered for asylum seekers that are low flight and security risk, particularly families with children. The environment is less institutional and more domestic than IDCs, with semi-independent living arrangements. Alternative Places of Detention include places like hospitals, schools, hotels and rented apartments. It is not clear how many people are in APOD in each state, or in which areas of the state they are located. Table 15 shows the breakdown by state of the number of adults and children in detention programs outside of IDCs.

Table 15 Number of people in alternative detention programs\*.

STATE	LOCATION OF IDC	ADULT		CHILD	TOTAL
		Male	Female		
WA	Perth IRH	2	2	7	11
NSW	Sydney IRH	8	10	10	28
SA	Port Augusta IRH	15	15	22	52
	Adelaide ITA	12	5	1	18
QLD	Brisbane ITA	33	12	18	63
VIC	Melbourne ITA	59	0	40	99
TOTAL IRH + ITA		129	44	98	271
Christmas Island	Christmas Island and Cocos Keeling Island APOD	232	226	354	812
Mainland	Mainland APOD	300	271	548	1119
TOTAL APOD		532	497	902	1931
TOTAL IRH + ITA + APOD		661	541	1000	2232

\* This includes Immigration Residential Housing; Immigration Transit Accommodation; and Alternative Places of Detention

Source: DIAC 2013<sup>162</sup>

# Community detention

In 2005, the Migration Act was amended to affirm that in principle, minors should be detained only as a measure of last resort<sup>164</sup>. Since this time, the Minister for Immigration has had the discretionary power to allow some asylum seekers, to enter a 'community detention' program (also known as 'residence determination')<sup>165</sup>. This program was expanded in 2010 and progressively over time, the number of children in IDCs has declined to zero, although a significant number also remain in the other detention programs described above.

Community detention allows asylum seekers to live freely in the community without the supervision of an immigration officer. It is mainly utilised for unaccompanied minors and vulnerable family groups. DIAC also tries to house vulnerable single adult males in these facilities where appropriate. Unaccompanied minors are under guardianship of the Minister for Immigration and Citizenship<sup>166</sup>. They are generally housed together with 24 hour supervision and are required to attend school.

Australian Red Cross is the main agency to operate this program under government contract<sup>167</sup>. DIAC also works with a number of non-governmental organisations to source housing, provide payment of living expenses, and to facilitate access to health, community and social support services. These differ by state and the groups they are responsible for, but include:

- Adult Multicultural Education Services
- Anglicare
- Berry Street
- Catholic Care
- Centacare
- Centrecare Migrant Services
- Hotham Mission Asylum Seeker Project
- Jesuit Social Services
- Jesuit Refugee Services
- MacKillop Family Services
- Marist Youth Care
- Metropolitan Migrant Resource Centre
- Mercy Family Services
- Multicultural Development Association
- The Salvation Army

People living in community detention arrangements have no lawful status in Australia. They do not hold a visa or have any rights or entitlements, unlike asylum seekers living in the community on a bridging visa. While in community detention, asylum seekers are required to live at the allocated address and regularly report to the immigration department or another service provider<sup>165</sup>. They are provided with a basic living allowance, which is the equivalent of 70% of Centrelink Special benefit rate (or 60% if the asylum seeker arrived by boat after August 13, 2012). Although this is a smaller living allowance, housing, furniture, medical and schooling expenses are mostly covered<sup>167</sup>. Community detention is considered a better environment for mental and physical health than IDCs and other detention programs. It allows individuals to begin to settle into the community with the support of case workers, while they await a decision on their visa.

As at 31 January 2013, there were 2178 people in community detention (Table 16). Of these:

- 474 (22%) were adult women
- 923 (42%) were children

Figures are not provided on how many people are in community detention in each state or exactly which areas these people are housed in by the agencies that facilitate their accommodation. This is dependent on the subcontracted organisations' ability to secure appropriate, affordable accommodation.

**Table 16: Number of people in community detention by nationality and gender**

COUNTRY OF CITIZENSHIP	ADULT		CHILD		TOTAL
	Male	Female	Male	Female	
Sri Lanka	286	214	152	110	774
Iran	143	72	130	47	392
Afghanistan	125	30	153	19	327
Iraq	72	37	42	19	170
Palestinian Authority	20	18	15	22	75
Other	153	103	131	83	470
<b>Total</b>	<b>781</b>	<b>474</b>	<b>623</b>	<b>300</b>	<b>2178</b>

Source: DIAC 2013<sup>162</sup>

## Health care provision in detention

### Overview

The federal government is responsible for facilitating health care to detainees. Because they have no visa status and no Medicare, all health care services provided to asylum seekers in detention are coordinated by a company contracted by DIAC called International Health and Medical Services (IHMS). The inquiries conducted in immigration detention centres raised a number of serious concerns that attracted considerable domestic and foreign criticism. In response to this, an advisory group was established to provide independent advice to the government regarding the provision of health care to people in immigration detention. Formed in 2006, the Detention Health Advisory Group (DeHAG) involved a group of key experts in the field<sup>169</sup>, but has recently been replaced by another independent health advisory group IHAG. It is anticipated that IHAG will have a broader scope that will advise on the needs of asylum seekers not only in detention, but also in the community and recent Humanitarian Visa holders<sup>170</sup>.

In 2007, the Detention Health Framework was established to address some of the health concerns in detention centres<sup>87</sup>. DeHAG and other key experts contributed to the development of the framework. It requires the health services provided in immigration detention to be comparable to those provided to the general community. IHMS are required to meet accreditation standards that have been set by the Royal Australian College of General Practitioners<sup>59</sup>.

DeHAG have been particularly critical of the health services provided to asylum seekers in detention, particularly related to mental health services<sup>171</sup>. They have stated that the services provided are inadequate to address the psychological needs of asylum seekers; and policies relating to psychological support and survivors of torture and trauma were not being implemented. In the Joint Select Committee report, additional concerns were raised around mental health screening and the inconsistent identification of detainees at risk<sup>59</sup>. Further, it has been questioned whether IHMS have the ability to meet the mental health needs of asylum seekers who continue to be detained against professional advice. There are few outreach services to remote detention centres and it has been difficult to facilitate the visitation of psychiatrists. Cases whereby people have been returned to detention after receiving treatment in hospital for psychological illness raise serious concerns<sup>59</sup>.

## Immigration detention centres

In IDCs, a GP, nurse, counsellor and psychologist are employed to provide primary health care as required. Every person in detention will undergo screening for communicable diseases and an initial health assessment, involving a medical history, physical and mental assessment. Primary health services are usually provided onsite with referral to external specialty services facilitated as required, including the management of acute and emergency care through local hospitals. Regularly monitoring and screening including quarterly mental health assessments is undertaken in detention centres, however the procedures involved have been identified as inappropriate and rushed<sup>59</sup>. To promote continuity of care upon release from detention, asylum seekers are provided with a discharge health summary, which outlines their known medical history, and any diagnoses or treatment undertaken in detention<sup>172</sup>. Referral may be made to community-based services to facilitate ongoing care.

Although the quality of general care provided appears to be good, concerns have been raised around the hours of operation<sup>59</sup>. Some immigration detention centres have restricted clinical hours and considering the high rates of mental illness, self-harm and previous deaths in detention due to suicide, the need for 24 hour paramedic services has been highlighted. Detention centres that are located in remote locations may be particularly vulnerable to delays in receiving adequate care. Local health services that clients are referred to from detention centres can reclaim costs associated with consultation and treatment through IHMS (and subsequently DIAC). Some state and territory local health services have in-principle agreements or Memoranda of Understanding (MOUs) around meeting the costs of additional overheads and staffing requirements.

## Community detention and immigration residential housing

Asylum seekers in community detention and immigration residential housing arrangements attend community-based health services on a needs-basis, with coordination from IHMS, who facilitate and pay for a range of specified health services<sup>173</sup>. Generally, IHMS will assign a primary health clinic and pharmacy that is close to where people are residing. These services have been credentialed by IHMS and enter an agreement to provide certain services at a specified rate. Case workers will generally arrange for asylum seekers in community detention to receive a health assessment from a local GP upon entry into the detention program and will assist facilitation of other health services upon request<sup>173</sup>. The health services are required to provide an interpreter service at the request of the client or caseworker. The client may already have a Health Discharge Assessment from their initial screening upon arrival to Australia (and any further assessment or treatment they received)<sup>172</sup>.

Asylum seekers in community detention should be provided health services comparable to that provided to a citizen in the Australian community. DIAC will cover the costs of <sup>173,174</sup>:

- GP consultations
- Specialists in the public health system through GP referral
- Some private specialist consultation, with prior approval required

- Prescription medication
- Over the counter medication if prescribed by a GP
- Special items or equipment specific to health conditions (Red Cross info sheet)
- Surgical intervention in the public health system, with prior approval required
- Imaging, pathology
- General dental (initial appointment only; further approval required for treatment)
- Optometrists
- Psychologists/psychiatrists
- Free counselling services such as through the FASSTT network

Additional health care costs may be covered in certain circumstances with approval of DIAC. All other costs must be paid for by the client. In addition, DIAC has agreements with all State governments that asylum seekers can access free emergency health care at all public hospitals. This includes ambulance transport, consultations and tests undertaken in an emergency department.

If an asylum seeker in community detention presents to any Victorian public health service to access the services listed below, DIAC will reimburse the Victorian state funded service provider on a fee-for-service basis<sup>174</sup>. There are formal billing procedures in place. It is important that reimbursement is requested because otherwise the costs are absorbed by the Victorian Department of Health, rather than through DIAC.

Health and related services may include:

- Admitted and non-admitted patients services
- Ambulance
- Pharmaceuticals
- Primary and community health
- Mental health
- Immunisation services
- Aged support services
- Preventative health
- Interpreting services
- Drug and alcohol services
- Aids and equipment\*
- Dental\*

\* requires separate approval by IHMS & DIAC through the client case manager

*It is unclear whether formal procedures have been established between IHMS and the departments of health in NSW and QLD; further enquiry is required.*

# Community-residing asylum seekers

In the previous section we have given an overview of the offshore and onshore humanitarian program, the application process and grant rates for non-IMAs and IMAs. The following sections explore the policy related to asylum seekers living in the community. As already stated, these are usually people who arrive by plane with a substantive visa (considered 'lawful') and therefore not subject to mandatory detention. They may also arrive by boat and placed in immigration detention before being released into the community while they wait for a decision on their protection visa. The aim of this section is to: describe the types of visas asylum seekers can hold while their application is processed; outline the available statistics on this group; and clarify what government services they are entitled to.

## Bridging Visas

Asylum seekers may be granted a bridging visa in order to allow them to remain in Australia lawfully in the community while their application for a protection visa<sup>5</sup> is being processed. Generally, this concerns asylum seekers who arrive by plane, however may also include those who are released from immigration detention (this will be covered in more detail below).

The entitlements of an asylum seeker depend on the type of visa they are granted and accompanying conditions<sup>175</sup>. There are five classes of bridging visas, four of which may be granted to an asylum seeker – bridging visa A, B, C or E. In general, if the visa grants work rights, this means the person is also eligible for Medicare. A bridging visa may permit full time work; limited work; or no work. With a bridging visa, asylum seekers can choose where they wish to live as long as DIAC is notified of their current residence at all times. They generally live in private rental properties, not public housing, but many face barriers in the rental market and so rely on friends, relatives or charities to provide accommodation<sup>24</sup>. Bridging visa holders may be required to report to DIAC at regular intervals.

Cessation of a bridging visa will occur if a protection visa is granted; or 28 days after notification of a decision to refuse the protection visa either through the primary decision by DIAC, or through merits review<sup>175</sup>. If the person wishes to pursue judicial review, they will generally be required to apply for another bridging visa to maintain their lawful status.

There are a number of circumstances relevant to onshore asylum seekers for which a bridging visa will be granted:

- A person who applies for a protection visa onshore and is awaiting a decision on that application
- A person who applies for a merits or judicial review of a decision to refuse an application for a protection visa
- A person who has requested Ministerial Intervention over a decision to refuse an application for a protection visa
- A person whose application has been rejected and is making, or is the subject of, arrangements to leave Australia

## Bridging Visa A (BVA)

A person who arrives with a 'substantive' (valid) visa, such as a student visa, tourist visa or business visa and then applies for a protection visa before their original visa expires, will be granted a BVA. The BVA will become valid when the substantive visa ceases. Asylum seekers are generally permitted work rights when granted a BVA, provided they remain lawful, apply soon after their arrival in Australia and comply with the conditions of

<sup>5</sup> This also applies to people who are not seeking asylum but are applying for other substantive visas

the visa. Generally this bridging visa concerns asylum seekers who arrive by plane, although this group may also be granted one of the other bridging visas.

- As at 25 May 2012, there were 2452 asylum seekers on a BVA, of which 2426 (99%) had work rights (Table 17)

## Bridging Visa B (BVB)

This visa is granted in exceptional circumstances to people who are already holding a BVA and need to leave Australia during the visa application process.

- As at 25 May 2012, there were 33 asylum seekers on a BVB, of which 32 (97%) had work rights (Table 17)

## Bridging Visa C (BVC)

A person who does not hold a substantive visa when they apply for a protection visa (such as someone who has overstayed their arrival visa and then applied for a protection visa) but has not been located by the department, will be granted a BVC. An asylum seeker with a BVC may have work restrictions, but this can be overturned in some cases (see below).

- As at 25 May 2012, there were 1226 non- IMA asylum seekers on a BVC, of which 651 (53%) had work rights (Table 17)

## Bridging Visa E (BVE)

BVE holders comprise two different groups of asylum seekers. The first group concerns people who arrive 'lawfully' with a substantive visa but who delay applying for a protection visa until after their original visa had expired, and have therefore become 'unlawful'<sup>175</sup>. An asylum seeker who applied for a protection visa after overstaying their substantive visa is more likely to have work restrictions. There are some discretionary provisions that may allow some BVE holders to apply to have work restrictions overturned, although it is considered difficult (see below).

- As at 25 May 2012, there were 843 non-IMA asylum seekers on a BVE, of which 178 (21%) had work rights (Table 17)

The second group of BVE holders relates to policy changes that occurred in November 2011 and involve asylum seekers who arrive 'unlawfully' by boat without a valid visa (see below).

## Bridging Visa E Grants to 'Irregular Maritime Arrivals'

On 25 November 2011, DIAC announced it would be allowing more asylum seekers, who arrived in Australia by boat without a substantive visa, to live in the community while awaiting a decision on their protection visa<sup>176</sup>. This means that although immigration detention is still mandatory for this group, in some cases time spent in detention is limited to conducting health, security and character checks.<sup>177</sup> They are not in community detention. Originally all asylum seekers granted a BVE had automatic work rights and Medicare. However, the Australian Government announced that based on the principle of 'no-advantage', any IMAs arriving post August 13, 2012 that are released from detention to live in the community, would *no* longer be granted work rights (although they *do* have access to Medicare). This puts them at a significant disadvantage to other BVE holders who do have the right to work.

Currently (March 2013), the department is releasing up to 2,000 asylum seekers from detention per month<sup>178</sup>, although the exact numbers fluctuate. Under the new policy, a number of criteria determine the issuing of BVEs to asylum seekers in detention. Priority is generally given to those who<sup>179</sup> :

- Have spent the longest time in detention



- Are vulnerable (such as identified torture or trauma experiences)
- Have had a positive behavioural record while detained
- Have appropriate community support in the way of family, friends and accommodation

Bridging Visa holders are able to access Medicare services once they have been registered and receive an Interim Medicare Card. As discussed in section 3, there have been some problems for eligible asylum seekers registering for Medicare. The Orientation and Triage Sessions conducted with BVE holders in Melbourne has helped to improve this situation as part of the program involves assistance with Medicare registration and education of GPs working in the local community.

Despite access to work rights for some, Medicare and immediate support upon release (see community assistance schemes), asylum seekers released from detention on BVEs are considered to be a highly vulnerable group. Consultation with people working with asylum seekers suggests that many of those released have spent considerable lengths of time in immigration detention centres and so may have become 'institutionalised'. A shortage of housing, no rental record and insufficient income means that many are required to share rental houses. This group of asylum seekers are thought to be more transitory due to work and accommodation instability and may make them less likely to attend to their health care needs including follow up.

## Removal Pending Bridging Visa (BVR)

This visa was introduced in May 2005 for people who are in immigration detention and are to be deported from Australia but this process is not 'reasonably practical'<sup>180</sup>. They must have been cooperating with DIAC to resolve their immigration issues and be doing everything possible to facilitate their departure. BVR holders have access to a range of benefits including: work rights; Medicare; some Centrelink benefits; early health assessment and intervention services; counselling; and education for children. As at 25 May 2012, no asylum seekers held a BVR (Table 17).

For a summary of the bridging visas and corresponding entitlements, see Table 29.

## Policy around work rights

Policy around permission to work is integral to this project, because in general, asylum seekers with bridging visas in the community that grant permission to work can also access Medicare. The policy around permission to work is highly complicated with some aspects considered 'operational law' (inalterable rules) and other aspects being 'discretionary' (DIAC staff can make some decisions with consideration of individual circumstances). According to staff at DIAC, the policy around work rights aims to support asylum seekers who have genuine claims, while attempting to deter those who have insubstantial claims and may be using the protection visa process simply as a means to remain in Australia. Delaying an application for protection is seen as an indication that the person is less likely to have a 'genuine' claim.

On July 1, 2009 new 'permission to work arrangements' came into effect<sup>181</sup>. In general, work rights are offered to those who:

- Remain lawful at all times (continue to hold a valid Substantive or bridging visa)
- Meet time limits (e.g. apply for tribunal review within 28 days)
- Actively engage with the department (e.g. present when requested, notify DIAC of change of address)

According to the policy, permission to work can be made available to those at the primary and review stages of a protection visa application, or even those seeking Ministerial Intervention as long as they comply with the above conditions. By contrast, asylum seekers who are denied work rights are those who arrive lawfully in Australia but delay applying for a protection visa until after their substantive visa expires, or those subject to the 'No advantage' principle. If an asylum seeker is not granted work rights with their bridging visa, this

can be overturned in some cases<sup>175</sup>. To be granted work rights, the individual must be able to demonstrate a “compelling need to work”; that is, provide evidence to DIAC of financial hardship and an inability to pay for basic living expenses. The individual must also provide acceptable reasons as to why they failed to apply for a protection visa while they still had a substantive visa, and subsequently became unlawful. Acceptable reasons generally must involve factors that were outside the control of the individual, such as serious illness. Even for those asylum seekers on bridging visas with work rights, there remain significant barriers to securing paid employment. These challenges are highlighted in section 1.

Table 29 provides a summary of the bridging visas and eligibility for government services. It is important to remember that asylum seekers may move between visa categories during the application process so their eligibility may change over time.

## Unlawful people in the community

It is important to note that there are a number of people living in the community who have breached their visa conditions, some of which may have originally applied for, or had the intention of applying for, a protection visa. Although this group do not strictly fit the criteria of asylum seekers, these people are more likely to be vulnerable, marginalised and facing poverty, similar to many on bridging visas in the community. DIAC do not have accurate figures on the number of people living unlawfully in the community who have fled countries where they faced torture, trauma or persecution. These people are likely to be highly fearful of authority and may be reluctant to seek out health services. Service providers are not obliged to notify DIAC of known unlawful people, but situations where an unlawful person seeks medical attention might create challenges in terms of confidentiality and protecting the interests of the patient.

## Community-residing asylum seeker statistics

The following data on asylum seekers living in the community on bridging visas are separated by their mode of arrival: non-IMAs and IMAs. The reason for this is because the release of IMAs from detention with bridging visas is a new initiative and so statistical reports and other sources of data from previous financial years did not need to account for this group. At the time of this study update (March 2013), detailed statistics on IMAs on BVEs had not been released by DIAC since June 2012.

### Statistics on plane arrivals/non-IMAs

DIAC provided our project team with some statistics on asylum seekers in the Australian community with bridging visas, as at 25 May 2012. While these provide some useful insight into the numbers known at that time, they are likely to be an underestimate because they do not account for:

- The number of people awaiting judicial review or seeking ministerial intervention at this time
- The number who are on a negative pathway but not appealing through other legal routes (i.e. will return voluntarily or involuntary to their country or cannot be returned)
- Asylum seekers who have been granted a bridging visa, but whose original substantive visa is still active

Unfortunately, DIAC were unable to provide the project team with these figures

## Non-IMAs in the Community

As at 25 May 2012, there were 4554 non-IMAs living in the community with bridging visas awaiting the outcome of a protection visa application at the primary and review stages<sup>182</sup>. Of these:

- 3287 (72%) have work rights and are therefore eligible for Medicare
- 1267 (28%) don't have work rights and are therefore not eligible for Medicare
- The majority (54%) of asylum seekers in the community are bridging visa A holders

It is encouraging to see that the majority of asylum seekers (non-IMAs) in the community have work rights. These statistics however, do not include non-IMAs who have been rejected at the independent review stage. With consideration of the statistics at hand, as discussed in section 1, it can be extraordinarily difficult for asylum seekers to find and maintain employment. Even with work rights, the majority of asylum seekers have little or no independent means of income and rely on charitable organisations to meet even basic living expenses. Having no means of earning an income, it is unclear how asylum seekers without work rights are expected to cover their medical expenses. The challenges associated with the denial of Medicare rights are explored towards the end of this section and in section 3.

**Table 17: Number of non-IMA bridging visa holders with work rights at primary and review stages\***

BV CLASS	WITH WORK RIGHTS		NO WORK RIGHTS		ALL CASES	
	Number	Percentage	Number	Percentage	Number	Percentage
BVA	2426	53.3%	26	<1%	2452	53.8%
BVB	32	<1%	1	<1%	33	0.7%
BVC	651	14.3%	575	12.6%	1226	26.9%
BVE	178	3.9%	665	14.6%	843	18.5%
BVR	0	0%	0	0%	0	0%
<b>Total</b>	<b>3287</b>	<b>72.2%</b>	<b>1267</b>	<b>27.8%</b>	<b>4554</b>	<b>100%</b>

\*Valid as at 25 May 2012

Source: DIAC 2012<sup>182</sup>

## Applicant stages

Of those applying for protection visas, 2386 were awaiting a decision at the primary stage (DIAC delegate) (Table 18) and 2168 were awaiting a decision at the review stage (independent tribunal) (Table 19).

At both stages of the application process, the proportion of non-IMAs with bridging visas granting them work rights remained relatively stable (71.5-73%).

**Table 18: Number of non-IMA bridging visa holders with work rights at the primary stage**

BV CLASS	WITH WORK RIGHTS		NO WORK RIGHTS		ALL CASES	
	Number	Percentage	Number	Percentage	Number	Percentage
BVA	1351	56.6%	12	0.5%	1363	57.1%
BVB	21	0.9%	0	0%	21	0.9%
BVC	256	10.7%	356	14.9%	612	25.6%
BVE	79	3.3%	311	13.0%	390	16.3%
BVR	0	0%	0	0%	0	0%
<b>Total</b>	<b>1707</b>	<b>71.5%</b>	<b>679</b>	<b>28.5%</b>	<b>2386</b>	<b>100%</b>

Source: DIAC 2012<sup>182</sup>

**Table 19: Number of non-IMA bridging visa holders with work rights at the merits review stage**

BV CLASS	WITH WORK RIGHTS		NO WORK RIGHTS		ALL CASES	
	Number	Percentage	Number	Percentage	Number	Percentage
BVA	1075	49.6%	14	0.6%	1089	50.2%
BVB	11	0.5%	1	<0.1%	12	0.5%
BVC	395	18.2%	219	10.1%	614	28.3%
BVE	99	4.6%	354	16.3%	453	20.9%
BVR	0	0.0%	0	0.0%	0	0.0%
<b>Total</b>	<b>1580</b>	<b>72.9%</b>	<b>588</b>	<b>27.1%</b>	<b>2168</b>	<b>100%</b>

Source: DIAC 2012<sup>182</sup>

## State of residence

Data on the residential location of all asylum seekers (non-IMA) living in the community are only known by state - not by suburb or local government area. We can make some assumptions about the residential location of asylum seekers through separate data available on IMAs on BVEs and refugees more generally, as these populations tend to reside where other people of their cultural background are living. For more data on where refugees (with permanent residency status) are living in Australia, see the 'Settlement outcomes of new arrivals' report, 2011 and the maps in the appendices. It appears that greatest numbers of asylum seekers (non-IMAs) are living in NSW, followed by Victoria and then Queensland. The percentage of those with work rights and Medicare is also highest in NSW, followed by Victoria and then Queensland.

The following data relate to non-IMAs with bridging visas living in each state at the primary and merits review stages. Please note there are statistics available that are not listed here including numbers for the other states and a breakdown by review stage. There are 303 additional people whose state of residence is not known and so the figures below are estimates. Like the previous few tables, these numbers were valid as at 25 May 2012 and only account for non-IMAs at primary and review stages.

## Victoria

Table 20: Number of non-IMA bridging visa holders in Victoria with work rights\*

BV CLASS	WITH WORK RIGHTS		NO WORK RIGHTS		ALL CASES	
	Number	Percentage	Number	Percentage	Number	Percentage
BVA	663	51.6%	12	0.9%	675	52.5%
BVB	17	1.3%	0	0.0%	17	1.3%
BVC	153	11.9%	168	13.1%	321	25.0%
BVE	63	4.9%	209	16.3%	272	21.16%
BVR	0	0.0%	0	0.0%	0	0.0%
<b>Total</b>	<b>896</b>	<b>69.7%</b>	<b>389</b>	<b>30.3%</b>	<b>1285</b>	<b>100%</b>

Valid as at 25 May 2012; only includes those at primary and merits review stages

Source: DIAC 2012<sup>182</sup>

## New South Wales

Table 21: Number of non-IMA bridging visa holders in NSW with work rights\*

BV CLASS	WITH WORK RIGHTS		NO WORK RIGHTS		ALL CASES	
	Number	Percentage	Number	Percentage	Number	Percentage
BVA	1140	52.0%	4	0.2%	1144	52.2%
BVB	11	0.5%	1	<0.1%	12	0.5%
BVC	413	18.8%	269	12.3%	682	31.1%
BVE	49	2.2%	305	13.9%	354	16.1%
BVR	0	0.0%	0	0.0%	0	0.0%
<b>Total</b>	<b>1613</b>	<b>73.6%</b>	<b>579</b>	<b>26.4%</b>	<b>2192</b>	<b>100%</b>

Valid as at 25 May 2012; only includes those at primary and merits review stages

Source: DIAC 2012<sup>182</sup>

## Queensland

Table 22: Number of bridging visa holders in QLD with work rights\*

BV CLASS	WITH WORK RIGHTS		NO WORK RIGHTS		ALL CASES	
	Number	Percentage	Number	Percentage	Number	Percentage
BVA	192	51.8%	1	0.3%	193	52.0%
BVB	0	0.0%	0	0.0%	0	0.0%
BVC	27	7.3%	53	14.3%	80	21.6%
BVE	25	6.7%	73	19.7%	98	26.4%
BVR	0	0.0%	0	0.0%	0	0.0%
<b>Total</b>	<b>244</b>	<b>65.8%</b>	<b>127</b>	<b>34.2%</b>	<b>371</b>	<b>100%</b>

Valid as at 25 May 2012; only includes those at primary and merits review stages

Source: DIAC 2012<sup>182</sup>

### Substantive visa type

The demographics of non-IMAs are likely to differ significantly to IMAs due to their ability to travel to Australia by plane with a valid visa. As Table 23 indicates, more recently, the majority of protection visa applicants arrived on student visas, and 'visitor and working holiday' visas. The type of substantive visa that an asylum seeker arrives with may affect factors such as: their ability to earn income (even after applying for a protection visa, the bridging visa does not become active until the original substantive visa expires); whether they have social supports already in Australia; and whether they have undergone health screening prior to leaving their country of origin.

Table 23: Number of protection visas lodged by non-IMAs according to substantive visa group

VISA GROUP	2010-11	2011-12
Students	2668	3327
Visitors and working holiday makers	2607	2488
Temporary Residents (Economic)	149	174
Bridging visa	60	141
Family Migration	110	130
Temporary Residents (Non-economic)	58	93
Other	685	683
<b>Total</b>	<b>6337</b>	<b>7036</b>

Source: DIAC 2012<sup>155</sup>

## Country of citizenship

The country of citizenship on non-IMAs (Table 24) differs significantly to those who arrive by boat. Country of citizenship will have an impact on the: health needs; cultural and social beliefs; and level of health literacy of asylum seekers; as well as their health profiles.

**Table 24: Top 10 countries of citizenship of non-IMA protection visa applicants**

CITIZENSHIP	2010-2011		2011-2012	
	Number	Percentage	Number	Percentage
China (PRC)	1124	17.7%	1216	17.3%
India	556	8.8%	906	12.9%
Pakistan	549	8.7%	667	9.5%
Iran	386	6.1%	462	6.6%
Egypt	427	6.7%	357	5.1%
Iraq	221	3.5%	297	4.2%
Fiji	331	5.2%	271	3.9%
Nepal	229	3.6%	241	3.4%
Malaysia	212	3.3%	196	2.8%
Lebanon	174	2.7%	182	2.6%
Other	2128	33.6%	2241	31.8%
<b>Total</b>	<b>6337</b>	<b>100.0%</b>	<b>7036</b>	<b>100.0%</b>

Source: DIAC 2012<sup>155</sup>

## Sole applicants and dependents

Most non-IMA asylum seekers are sole applicants; that is they lodge a protection visa application on their own. Of the smaller proportion of asylum seekers that are not sole applicants, on average they apply with two dependants (Table 25). A dependant can be a spouse, child or other person who is directly dependent on the applicant to meet their immediate needs.

**Table 25: Number of sole and accompanied non-IMA protection visa applicants**

PROGRAM YEAR	PRINCIPLE APPLICANTS			DEPENDANTS	TOTAL (APPLICANTS AND DEPENDENTS)
	Sole applicants	Accompanied applicants	Total		
2011-12	4285	965	5250	1786	7036
2010-11	3846	909	4755	1582	6337

Source: DIAC 2012<sup>155</sup>



## Gender and age

In general, a greater number of non-IMA protection visa applicants are male than female. Similar to asylum seekers arriving by boat, a large proportion of non-IMAs are in the 18-30 age bracket (Table 26). Both gender and age are important considerations because this will affect the health profile of the asylum seeker population.

**Table 26: Non-IMA asylum seekers by gender**

PROGRAM YEAR	PRINCIPLE APPLICANTS		DEPENDANTS		ALL NON-IMA ASYLUM SEEKERS	
	Male	Female	Male	Female	Male	Female
2011-12	70.4%	29.60%	45.1%	54.9%	64.0%	36.0%
2009-10	70.0%	30.0%	42.9%	57.1%	63.2%	36.8%

Source: DIAC 2012<sup>155</sup>

**Table 27: Age of non-IMA asylum seekers at time of lodgement**

AGE CATEGORY	2010-11	2011-12
0-17 years	876	1041
18-30 years	2893	3306
31-40 years	1348	1422
41-50 years	716	735
51-60 years	303	302
60+ years	201	230
<b>Total</b>	<b>6337</b>	<b>7036</b>

Source: DIAC 2012<sup>155</sup>

## Statistics on IMAs living in the community on a BVE

As previously discussed, since November 2011, there has been a deliberate attempt to place IMAs in the community with a bridging visa E (BVE). Between 25 November 2011 and 25 October 2012, over 7,400 asylum seekers were released from detention and granted a BVE<sup>183</sup>. Many of these have since been granted protection visas. More recent figures had not been released at the time of this report and little is known about the demographics of this cohort, although community services concur that nearly all of these asylum seekers are young adult males.

## State of residence and citizenship

The mobility of this group in the community is generally tied to employment and housing opportunities. As at June 30, 2012, the greatest number of IMAs with BVEs were living in Victoria, followed by NSW, WA and QLD (Table 28). Appendices have been attached showing areas in each state where asylum seekers are likely to be residing, based on settlement data.

Table 28: Number of IMAs on BVEs by citizenship and state of residence

COUNTRY OF CITIZENSHIP	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	ALL STATES
Afghanistan	13	131	6	72	185	7	369	136	919
Iran	20	178	19	76	40	14	180	48	575
Sri Lanka	3	74	9	48	9	7	134	50	334
Iraq	3	83	1	11	4		27	22	151
Stateless	8	59	6	17	3		44	9	146
Pakistan	1	19	5	11	6	1	55	12	110
Other		24	11	19			9	8	71
<b>Total number</b>	<b>48</b>	<b>568</b>	<b>57</b>	<b>254</b>	<b>247</b>	<b>29</b>	<b>818</b>	<b>285</b>	<b>2306</b>

Source: DIAC 2012<sup>177</sup>

## Community-residing asylum seeker benefits and entitlements

### Community assistance schemes

Some asylum seekers may be eligible for government-funded programs that aim to assist people while their protection claims are being assessed. This includes:

- Financial assistance and limited casework services through the Asylum Seeker Assistance Scheme (ASAS)
- Financial assistance and intensive casework services through the Community Assistance Support (CAS) program
- Transitional support through the CAS program for asylum seekers released from detention
- Legal assistance through the Immigration Advice and Application Assistance Scheme (IAAAS)

### Asylum Seeker Assistance Scheme (ASAS)

During 2011–12, assistance was provided to 3083 people at a cost of \$11.6 million through the ASAS<sup>153</sup>. In Victoria, NSW and Queensland the Australian government has contracted the Australian Red Cross, Multicultural Development Agency (MDA), Adult Multicultural Education Services (AMES), Settlement Services International (SSI) and ACCESS Community Services (ACCESS) to administer the ASAS program. If an asylum seeker is eligible for this scheme, they may receive<sup>184</sup>:

- Limited financial assistance up to the equivalent of 89% of Centrelink Special Benefit. This is intended to assist with living expenses.

- They may also be able to receive some additional limited financial assistance for health care costs, which is generally similar to what Medicare holders are eligible for, as well as pharmaceuticals at the Health Care Card rate
- Other financial assistance may be available for visa health screening and character checks.
- In addition, casework assistance is designed to facilitate referral to health services, counselling, accommodation, material aid such as clothing and furniture, education, legal services and social support.

Initially, all asylum seekers were eligible for the ASAS if a decision on their immigration status was pending at 6 months. Over time however, eligibility criteria have become increasingly prohibitive<sup>73</sup>. The criteria are set by DIAC and all applicants must be approved by them.

The asylum seeker must<sup>184,185</sup>:

- Have lodged an application over 6 months ago and be waiting on a decision
- Be residing in the community
- Hold a bridging visa
- Not be eligible for any other type of income support in Australia or another country

Meet the exemption criteria and be waiting for a decision on a primary assessment or review by an independent tribunal. The person does not have to have been waiting for more than 6 months in this case.

The exemption criteria are designed to support vulnerable asylum seekers who may be suffering financial hardship and lack adequate support from the community to provide for their daily needs. These cases are assessed individually and may include<sup>184,185</sup>:

- Unaccompanied minors
- Elderly persons
- Families with children under 18 years of age
- Pregnant women
- People who are unable to work due to a disability, illness, care responsibilities or the effects of torture or trauma
- People experiencing financial hardship resulting from a change in circumstances since arriving in Australia.
- The spouse, de facto or sponsored fiancé of a permanent resident

In reality, it can be really difficult to meet the exemption criteria for ASAS. Many people working with asylum seekers argue that a great number of asylum seekers who require support are missing out. For those fortunate enough to receive ASAS, accommodation support is not provided, so many asylum seekers and their families struggle to cover the cost of rent and face homelessness. At 89% of Centrelink Special Benefit, this puts asylum seekers with ASAS below the poverty line<sup>186</sup>. As of July 2012, only 29% of the 1253 clients at the Asylum Seeker Resource Centre were eligible for either ASAS or CAS<sup>186</sup>.

As of 31 July 2012, in Victoria<sup>187</sup>:

- 455 non-IMAs in the community were part of the ASAS program
- 553 IMAs in the community were part of the ASAS program

## Community Assistance Support (CAS) Program

The Australian government has contracted the Australian Red Cross, MDA, AMES, SSI and ACCESS to administer the CAS program. It is designed to assist people who are highly vulnerable and have complex needs. The program administers a range of services to improve the welfare and wellbeing of eligible clients.

This is dependent on the individual's circumstances but might include<sup>188,189</sup>:

- Complex casework support
- Income support to cover basic living expenses (equivalent to 89% of Centrelink Special Benefit)
- Financial assistance for rent (equivalent to 89% of Centrelink Rental Assistance)
- Access to health care including emergency hospitalisation and ambulance services
- Access to counselling
- Assistance with accessing accommodation; crisis, medium term and supported accommodation through referrals to housing service providers
- Other assistance as agreed to meet client needs
- Transition support for some vulnerable people leaving immigration detention facilities who have been granted a substantive visa (see below)

To be eligible for CAS, clients must be referred by DIAC Case Management and satisfy all of the following criteria<sup>188,189</sup>:

- Hold a bridging visa that is in effect
- Have an unresolved immigration status and be cooperating with the department to resolve their immigration status
- Be unable to access adequate support in the community or be unable to support themselves
- Be highly vulnerable due to at least one of the following criteria:
  - have a diagnosed mental health condition
  - have a significant disability or serious health issue
  - being an elderly person
  - being a minor at risk of harm, including an unaccompanied minor
  - suffering the effects of torture and trauma
  - suffering domestic abuse or violence
  - suffering impaired mental or physical ability

As of July 2012, in Victoria<sup>187</sup>:

- 63 non-IMAs in the community were part of the CAS program
- 83 IMAs in the community were part of the CAS program

Eligibility for the ASAS and CAS programs ceases if an asylum seeker has received a negative decision at the independent merits review stage, so asylum seekers appealing through Judicial Review or Ministerial intervention are no longer eligible for CAS or ASAS funding, except in exceptional circumstances based on significant vulnerability<sup>187</sup>. The number of asylum seekers who are living in the community that are *not* linked in with CAS or ASAS programs could not be determined.

## CAS Transitional Support (Bridging)

The Community Assistance Support Transitional Support (CAS Transitional Support) program was established to assist most people who are transitioning from immigration detention (IMAs) into the community on a BVE.

This support is available on a short-term basis only, usually for a period of six weeks. The program is facilitated by the same organisations that operate CAS and ASAS and includes<sup>190</sup>:

- Limited group case work support for referrals and coordination with other community services and organisations
- A fortnightly allowance equivalent to 89% of Centrelink benefit.
- Additional rent assistance may be approved in some circumstances
- Information and orientation sessions in the community
- Emergency accommodation for 4 weeks with possible extension in some circumstances
- Linkages for housing services

At around the 5 week mark, individuals are reassessed and referred for further support through ASAS or CAS if necessary. After the initial 6 week Transitional CAS program, of the IMAs on BVEs<sup>191</sup>:

- Approximately 70% are referred for ASAS support
- Approximately 15% are referred for CAS support
- Approximately 15% are independent

At present, Australian Red Cross is contracted to support up to 500 IMAs per month transitioning into the community. In addition AMES, ACCESS, SSI and MDA have recently also been contracted by DIAC and will support additional asylum seekers every month across Victoria, NSW and Queensland. Families are more likely to be placed in community detention arrangements rather than released with BVEs. However, any families that are on BVEs would receive assistance from Humanitarian Settlement Services (the organisation responsible will differ in each state) rather than Red Cross. This is because they are considered to be “1a Met”, which means they have had their refugee status confirmed but are awaiting security or other clearances.

In May 2012, the Community Placement Network (CPN) initiative was introduced. This is a government program that will enable Australian families to house asylum seekers who are released from immigration detention on bridging visas. The program is facilitated by the Australian Homestay Network<sup>192</sup>. As this is a new initiative, the success of the program is yet to be evaluated although overwhelming offers of assistance from families is encouraging. There are some concerns among community agencies that asylum seekers may be socially isolated from other refugees and asylum seekers who often provide a sense of safety and emotional support in the community. There may also be some families that view the program as an economic opportunity, rather than having a genuine interest in the welfare of asylum seekers.

## ASAS and CAS provision of health care

Clients with Medicare eligible for ASAS or CAS can access health care services like any Australian citizen. Those that don't have Medicare will have any health care expenses paid for them – equivalent to Medicare. There is the capacity for ASAS and CAS to provide services that aren't covered under Medicare, however each case must be separately considered and approval sought through DIAC. DIAC are wary of providing more than would otherwise be available to an Australian citizen. However, this fails to consider the fact that these clients are in the programs as a result of their vulnerability and they receive only 89% of the Centrelink benefit, putting them well below the income of many Australians who are eligible to receive a Health Care Card. ASAS and CAS can assist however by paying the gap between the cost of a pharmaceutical and the current concession card rate for PBS medicines. One issue that ASAS and CAS clients have is seeking out services that charge the Medicare Benefits Schedule. Some medical services wish to charge a higher fee, which DIAC would be unlikely to approve. In some areas, there may be few or no options available, requiring a client to travel long distances just to see a General Practitioner.

**Table 29: Outline of eligible services by visa status.**  
 (Source: Adapted from Victorian Refugee Health Network<sup>172</sup> and Refugee Council of Australia<sup>193</sup>)

	ASYLUM SEEKERS IN THE COMMUNITY (MAIN FOCUS OF PROJECT)			ASYLUM SEEKERS IN DETENTION		REFUGEES
	Typically plane (non-IMA) – applied early	Typically plane (non-IMA) – applied late	Typically boat (IMA) – detention then released	Typically boat (IMA)	Typically boat (IMA)	
Mode Of Arrival	Community-residing	Community-residing	Community-residing	Immigration Detention	Community Detention	Boat or plane – (Permanent residence granted onshore)
Residence Status	Community-residing	Community-residing	Community-residing	Immigration Detention	Community Detention	(Former asylum seekers, now permanent residents)
Visa Status	Bridging Visa A	Bridging Visa C or E	Bridging Visa E (decision pending)	No visa status	No Visa status	866 Protection Visa.: permanent residency
Work Rights/ Medicare	Usually yes	Usually no; can apply	Yes if arrived by boat prior to August 13, 2012 (No if after)	No	No	Yes
Health Care Provision	Medicare services (if work rights) comparable to Australian citizen	Usually no Medicare. Fee waiver depends on state policy. May rely heavily on pro-bono services.	Medicare services comparable to Australian citizen.	IHMS staff onsite	IHMS pay for approved health services from a network of health providers in community	Medicare services
Pharmaceuticals	PBS access (with Medicare). Health Care Card rates if ASAS/CAS	Full price unless charitable service can make arrangements. Health Care Card rates if ASAS/CAS	PBS access (with Medicare). Health Care Card rates if ASAS/CAS	IHMS cover costs	Provided through IHMS subcontracted pharmacy networks	PBS access (with Medicare) like other Australians
Health Care Card	No	No	No	No	No	Yes
Diac Funded Torture And Trauma Counselling	Yes	Yes	Yes	Yes	Yes	Yes; short term

ASYLUM SEEKERS IN THE COMMUNITY (MAIN FOCUS OF PROJECT)				ASYLUM SEEKERS IN DETENTION		REFUGEES
Housing	Private rental but may stay with friends, family or rely on charities. CAS receive assistance with low cost accommodation.	Private rental but may stay with friends, family or rely on charities. CAS receive assistance with low cost accommodation.	Private rental (may get emergency accommodation for 4-6 weeks with CAS Transitional support)	In IDC or other detention program. Little or no access to outside services	Cost fully covered by DIAC, facilitated by Red Cross/other agencies. Rental house, may share with other people/families.	Private rental. Eligible for rent assistance, public housing and household formation package.
Income Support	No; unless ASAS or CAS then equivalent to 89% of Centrelink Special Benefit	No; unless ASAS or CAS then equivalent to 89% of Centrelink Special Benefit	No; unless ASAS or CAS then equivalent to 89% of Centrelink Special Benefit	No	Yes; small living allowance paid by DIAC equivalent to 70% of Centrelink Special Benefit (or 60% if arrived post Aug 13)	Yes; all eligible Centrelink services
Education For Children	Yes; eligible for government primary and secondary schools and English Language Schools	Yes; eligible for government primary and secondary schools and English Language Schools	Yes; eligible for government primary and secondary schools and English Language Schools	Schooling is sometimes available with detention programs or negotiated with State governments. Inconsistent for secondary school.	Yes; eligible for government primary and secondary schools and English Language Schools	Yes; English Language School for 3-12 months and same access to schools as other permanent residents
Education For Adults	Informal volunteer-run programs. Some TAFE course access but have to pay.	Informal volunteer-run programs. Some TAFE course access but have to pay.	Informal volunteer-run programs	Some access to English language training through Serco programs. Access varies.	Some informal volunteer-run programs.	Yes; Adult Migrant English Program (510 hours), other language programs and same access to university, TAFE, higher education loans etc as permanent residents
Overseas Travel	Yes; in very exceptional circumstances	Usually no	Usually no	No	No	Yes



	ASYLUM SEEKERS IN THE COMMUNITY (MAIN FOCUS OF PROJECT)				ASYLUM SEEKERS IN DETENTION		REFUGEES
	No	IAAAS only for vulnerable clients	No	IAAAS	No	No	
Family Reunion	No	IAAAS only for vulnerable clients	No	IAAAS	No	No	Yes; with restrictions
Migration Legal Advice	IAAAS only for vulnerable clients	IAAAS only for vulnerable clients	IAAAS only for vulnerable clients	IAAAS	Yes; IAAAS	Yes; IAAAS	Yes; Legal aid and other legal centres that differ between states
Translating And Interpreting Services	Unclear – depends on service	Unclear – depends on service	Yes	Yes	Interpreters in detention centres or by phone/video link	Yes	Yes
Community-Based Case Work Support	Yes intensive support if CAS; limited if ASAS. Some informal case management through charitable organisations	Yes intensive support if CAS; limited if ASAS. Some informal case management through charitable organisations	Yes; first 4-6 weeks if receiving CAS Transitional (Bridging) support then assessed for CAS/ASAS	Yes	N/A	Yes; DIAC and Red Cross sub-contracted organisations. 24hr support for unaccompanied minors	Humanitarian Settlement Services (organisations differ between states)
Diac Case Management (Status Resolution)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Employment Services	No; some charitable organisations may assist	Generally not eligible to work	Job Services Australia as stream 1 clients (restricted). Some assistance through CAS Transitional Support.	N/A	N/A	N/A	Yes; Job Services Australia and Job Placement Employment and Training services

\*Please note the above description for IMAs released from detention on a BVE does not include those who are '1a Met' or 'Community Support Intensive'. These groups are eligible for most HSS services (that are granted to refugees once they have received a permanent visa).

# Health service benefits

## Medicare

Asylum seekers may be able to access Medicare if they have a bridging visa with work rights. If eligible, asylum seekers have access to the same health services offered to Australian citizens and are not given preferential treatment - they are subject to the same waiting periods as the general public. However, some states have improved access to vulnerable patients or those with complex needs and so through these schemes, asylum seekers may be able to be fast-tracked (see section 3).

As discussed further in section 3, the health care needs of Medicare-ineligible asylum seekers are met through a variety of federal and state government policies with enormous support from charitable organisations and pro-bono services. Some state health departments have created policies to ensure that community-residing asylum seekers' have fees waived. The extent of free community and tertiary services for Medicare-ineligible asylum seekers differs between states. Specialist services, diagnostics, pathology, medications, medical equipment and other health-related costs may be more difficult to negotiate fee-waivers for.

## Health Care Cards

A Health Care Card is usually provided to Australian citizens who are low-income earners. Regardless of their financial status, no asylum seekers (with or without Medicare) are eligible for a Health Care Card. This puts them at a considerable disadvantage because Health Care Cards assist in identifying patients who may be vulnerable and unable to pay for services. As a result, asylum seekers may have difficulty accessing bulk-billing services, affording medications, getting additional refunds for medical costs or being fast-tracked on some waiting lists. This also means that asylum seekers are also not eligible for other State and Local government concessions, such as utility bills or council rates. Asylum seekers without a Health Care Card are able to access transport concessions in Victoria.

## Pharmaceutical Benefits Scheme

Only people who are entitled to Medicare can access subsidised medicines through the PBS. This can make the cost of medications prohibitive for Medicare-ineligible asylum seekers and may result in the cessation of necessary treatment, particularly for chronic disease. Asylum seekers eligible for ASAS and CAS pay for pharmaceuticals at the equivalent to the Health Care Card rate.

### Immunisation Scheme

Immunisation is a shared responsibility between the Commonwealth and State governments. The Commonwealth is responsible for the funding of vaccines and some general practice services, while the State is responsible for logistics and public sector immunisation programs. There does not appear to be a specific Commonwealth policy on the immunisation of onshore asylum seekers. It is likely that recommendations pertaining to catch-up schedules for other immigrants would be referred to. See section 3 on state policies for more information on immunisation.

## Health care-related interpreter services

The Australian government provides a free on-site and telephone Translating and Interpreting Service (TIS) to assist non-English speaking Australian citizens and permanent residents to communicate with GPs, specialists, radiographers, pharmacists, and their support staff, when accessing Medicare or PBS funded services. For doctors, there is a priority line for medical consultations. Asylum seekers are not permanent residents and so are technically not eligible for TIS, but there are some exceptions. Most community-based

organisations and hospitals receive funding to cover the costs of interpreters, but this is often not adequate and so interpreters can be a significant cost burden. There are a number of other translating and interpreter services used throughout Australia. Allied health, some community health and mental health services cannot access free interpreters through the TIS, which creates significant barriers for asylum seekers.

All Australian Red Cross clients are eligible for TIS187. The charges must be allocated to a particular organisation and then funded by DIAC. Some of the challenges of interpreter services are discussed in greater detail in section 3.

## Community-based health screening

Asylum seekers who arrive in Australia with a substantive visa may have already undergone health screening, including formal medical and radiological assessment prior to arrival. This is dependent on intended length of stay, country of residence, age and reason for visit. Those arriving by boat will also be subject to health screening on arrival. As discussed previously, when a protection visa application is lodged by someone in the community, asylum seekers are required to undergo health screening, (regardless of pre-arrival screening) through Medibank Health Solutions (under contract from DIAC). This initiative may increase access to preventative care and decrease the risk of delayed treatment for medical conditions, assuming the individual is referred for follow up care.

## Other benefits and entitlements

A summary of other benefits and entitlements that are not health-related, such as housing and education, can be seen in Table 29 and is described in greater detail in sections 1 and 4.

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# Appendices

## Appendix A: Methodology of literature review

### Peer-reviewed literature

To identify articles of relevance for the purpose of a literature review, four different databases were systematically searched with key terms. In addition, the reference lists of articles were manually scanned to identify any relevant missing articles. A number of relevant websites and key experts were consulted during the process, including a librarian.

Due to the very limited number of articles discussing community-residing asylum seekers in Australia, the search was expanded to include any articles which focused on general and mental health issues related to asylum seekers in the community, or in detention centres in Australia. Any articles which explore the following areas of interest were identified, their full text version located and summarised in an annotated bibliography:

1. Risk factors, contributing factors to poor health
2. Types and prevalence of medical and mental health conditions
3. Community and tertiary service needs and utilisation rates
4. Inhibitors and facilitators to service access

### Inclusion/exclusion criteria:

1. All peer-reviewed articles including those reporting qualitative or quantitative data, literature reviews, editorials, commentaries and informative or educational pieces.
2. Articles published within the last 12 years (2000-12), in English
3. The main population group of interest being asylum seekers
4. Some articles discussing refugees on temporary protection visas were included, reasons for which are explored in the narrative.
5. Some articles discussing policy, ethics and health professionals included as it was felt this would add a different perspective and context to the broader scoping study.
6. Articles relating to policy issues like human rights violations, age identification, processing of asylum seekers or treatment guidelines/intervention efficacy were excluded as it was felt to be outside the scope of the review

### Grey literature:

Grey literature can be any information that is unpublished; or has not been published in a commercial form, such as factsheets, government or organisations' reports or conference proceedings. Grey literature was reviewed opportunistically, rather than systematically, based on its relevance to the scoping study. Websites of key refugee and asylum seeker agencies were the main source of grey literature and were used more frequently through the rest of the report.

## Appendix B: Annotated Bibliography

AUTHORS	YEAR	TITLE	JOURNAL	PUBLICATION TYPE AND KEY WORDS	SUMMARY OF CONTENT
Bowers, E. Cheng, I.	2010	Meeting the primary health care needs of refugees and asylum seekers	Research Roundup; 16	Informative Primary Health Care Medical conditions Access barriers	The author explores the difficulties faced in accessing primary care including: unfamiliarity of the health system, language barriers, distrust of government services or finding the assessment and treatment experience strange. The author identifies poor knowledge of medical issues, inefficient referral systems, poor transfer of health information, high refugee and asylum seeker patient loads and lack of collaboration as factors which can make primary health service provision inadequate and provides examples of more successful models to improve quality of care.
Briskman, L. Zion, D. Loff, B.	2010	Challenge and collusion: health professionals and immigration detention in Australia	International Journal of Human Rights: 14(7);1092-1106	Human rights and policy analysis Immigration detention Mental health Health professionals	Discusses the 'cruel' and 'inhuman' treatment of asylum seekers in immigration detention, in particular the practices of: force feeding in the context of hunger strikes; restraints used for deportation; and the incarceration of children. The authors state that professionals working in the detention environment face clinical and ethical dilemmas as a result of these harmful practices. They argue that health professionals should be more vocal in their opposition of the human rights violations that occur in these settings.
Coffey, G. Kaplan, I. Sampson, R. Tucci, M.	2010	The meaning and mental health consequences of long-term immigration detention for people seeking asylum	Social Science & Medicine: 70(12);2070-9	Qualitative and quantitative study Post detention Mental Health Refugees*	Reports the findings of semi-structured interviews and validated instruments with 17 previously detained adult refugees. The refugees "suffered an ongoing sense of insecurity and injustice, difficulties with relationships, profound changes to view of self and poor mental health. Depression and demoralisation, concentration and memory disturbances, and persistent anxiety were very commonly reported. Standardised measures found high rates of depression, anxiety, PTSD and low quality of life scores." The authors suggest that the findings reflect the consequences of long-term detention.



AUTHORS	YEAR	TITLE	JOURNAL	PUBLICATION TYPE AND KEY WORDS	SUMMARY OF CONTENT
Correa-Velez, I. Gifford, S. Bice, S.	2005	Australian health policy on access to medical care for refugees and asylum seekers	Aust New Zealand Health Policy: 2(23)	Policy analysis Immigration detention Access to community health care	Describes the policies and subsequent entitlements of refugees and asylum seekers as they apply to the various refugee and humanitarian visa categories. It draws attention to the limitations of the policy in particular asylum seekers unable to access Medicare due to restrictions on work rights. Although some of the policy has evolved since this time, namely the removal of temporary protection visas and changes around permission to work, many of the issues are still pertinent today.
Correa-Velez, I. Gifford, S.	2007	When the right to be counted doesn't count: the politics and challenges of researching the health of asylum seekers	Critical Public Health: 17(3);259-67	Policy and research methodology analysis Research	Highlights the lack of available data on asylum seekers, and the inability to determine prevalence rates due to the lack of a 'denominator', that is the total number of asylum seekers residing in the community at a given time. This issue causes conflict between public health researchers who are limited in their ability to develop high quality studies, and the Australian government who are reluctant to provide comprehensive figures. The authors suggest methods to estimate numbers on hidden populations like asylum seekers.
Correa-Velez, I. Johnston, V. Kirk, J. Ferdinand, A.	2008	Community-based asylum seekers' use of primary health care services in Melbourne	Medical Journal of Australia: 188(6);344-8	Quantitative study Community-residing asylum seekers Primary Health Care	This study involved a retrospective audit of the presentations of asylum seekers attending specialist clinics in Melbourne. Social problems were a common reason for presentation, including problems with housing, immigration, work, food or finances. The high rate of all presentations and complex medical and psychosocial needs reported, indicates the high burden that asylum seekers place on voluntary, pro-bono services.
Fazel, M. Silove, D.	2006	Detention of refugees	British Medical Journal: 332(7536);251-2	Editorial Immigration detention Mental Health Children	General discussion around the "failed" policy of immigration detention with a comparison between the UK and Australia in light of the changes made in Australia to release all children and their families from detention. The authors question whether mental health care in detention can ever be effective considering the setting is the root of the problem. They call for a shift to community detention models and for health professionals to lobby for policy change.



AUTHORS	YEAR	TITLE	JOURNAL	PUBLICATION TYPE AND KEY WORDS	SUMMARY OF CONTENT
Green, J. Eagar, K.	2010	The health of people in Australian immigration detention centres	Medical Journal of Australia: 192(2);65-70	Quantitative study Immigration detention Medical records	To determine the health status of asylum seekers in immigration detention, this study involved reviewing the electronic records of over 700 detainees. The most common complaints were for dental and respiratory conditions and lacerations. Although mental health was a concern for all groups in detention, the rates of new mental illness were 3.6 times higher in people who had been detained for over 24 months compared to those who were released within 3 months. Overall, the reason for, and time spent in detention was associated with health outcomes, most notably for mental health.
Harris, M. Zwar, N.	2005	Refugee Health	Australian Family Physician: 34(10); 825-9	Informative Community-residing refugees and asylum seekers Primary health care	An informative article discussing the sorts of health issues likely to be encountered among refugee and asylum seeker patients, such as physical and psychological sequelae of torture and trauma, anxiety, depression or post-traumatic stress disorder, infectious diseases such as tuberculosis, as well as chronic illness. The author suggests guidelines on assessment, management and referral and highlights the importance of preventative care.
Harris, M. Telfer, B.	2001	The health needs of asylum seekers living in the community	Medical Journal of Australia: 175(11);589-92	Literature review and discussion Community-residing refugees and asylum seekers Primary health care	The author discusses the health needs of asylum seekers, drawing attention to the fact that some living in the community might not have access to Medicare and face other barriers. He emphasises that doctors have a duty of care and ethical obligation to care for these patients.
Hutchinson, T. Martin, F.	2004	Australia's human rights obligations relating to the mental health of refugee children in detention	International Journal of Law & Psychiatry: 27(6);529-47	Human rights and policy analysis Immigration detention Children	A thorough analysis of Australia's human rights obligations in the context of detaining children in immigration detention. The author argues that current policies are not in the best interests of the child and detention should only be used as a last resort.

AUTHORS	YEAR	TITLE	JOURNAL	PUBLICATION TYPE AND KEY WORDS	SUMMARY OF CONTENT
Johnston, V.	2009	Australian asylum policies: have they violated the right to health of asylum seekers?	Australian & New Zealand Journal of Public Health: 33(1);40-6	Literature review and policy discussion Immigration detention Protection Visas Mental Health	A literature review examining the impact of Australian immigration policies on the mental health of asylum seekers. The author examines how immigration detention, temporary protection visas and the restriction of rights has contributed to post-migration stress. She questions whether Australia is upholding its obligations to provide asylum seekers with the same right to health as any Australian citizen and whether the current policy burdens asylum seekers with unnecessary additional physical and mental health problems.
Jureidini, J. Burnside, J.	2011	Children in immigration detention: a case of reckless mistreatment	Australian & New Zealand Journal of Public Health: 35(4);304-6	Editorial Immigration Detention Mental Health Human Rights	Discussion of the detention environment and how it can be harmful, especially for children. The authors argue that “alternative places of detention” are not a substitute for community housing as security and lack of freedom is still apparent. There are systemic and operational issues with the private health service provider, with communication difficulties between organisations and a lack of willingness to take responsibility for the health of detainees. Suggestions are made around more appropriate processing of asylum seekers.
Kardamanidis, K. Armstrong, B.	2006	The price of health care for Medicare-eligible asylum seekers in the community	Medical Journal of Australia: 184(3);140-1	Letter to the editor Medicare-eligible asylum seekers Primary and tertiary health care Economics	The authors highlight the inequalities in health care access to asylum seekers without Medicare eligibility. They provide examples of ‘tangible’ and ‘intangible’ costs. While some health professionals generously donate their time, many cannot address the full range of health care needs. Access to tertiary services and subsequent charges are inconsistent and seems subjective. The cost of denying full access to health services is likely to result in chronic or serious problems in the future, which could have been addressed with preventative care. For asylum seekers, this results in poorer physical, mental and social outcomes.

AUTHORS	YEAR	TITLE	JOURNAL	PUBLICATION TYPE AND KEY WORDS	SUMMARY OF CONTENT
Kardamandidis, K. Smith, M. Vagholkar, S.	2007	Bug Breakfast in the Bulletin: refugee health	New South Wales Public Health Bulletin: 18(1-2);26-7	Informative/educational Community residing refugees and asylum seekers Primary health care	A brief article about recently settled refugees (makes mention of asylum seekers). Some challenges associated with improving the health of newly arrived refugees include: ascertaining a reliable medical history; conducting tests and explaining results; the use of an interpreter; travel to and from the hospital for follow up; filling gaps in the immunisation schedule when history is unclear; the provision of medications not on the PBS; tuberculosis screening requirements; and health not being a priority in the context of other resettlement factors such as securing housing and education.
Katelaris, A. Harris, M.	2011	The profession calls for humane treatment of asylum seekers	Medical Journal of Australia: 195(6);309	Commentary Immigration detention Mental and physical health	The authors call for action to end the detention of asylum seekers for prolonged periods of time. The cite mental and physical harms, poor access to quality health care, high rates of actual and threatened self-harm (over 1 100 incidents in 12 months) and high costs (over \$800 million per year), as reasons to ensure detention centres are only used for the brief screening of health and security checks.
King, K. Vodicka, P.	2001	Screening for conditions of public health importance in people arriving in Australia by boat without authority	Medical Journal of Australia: 175(11-12); 200-2	Quantitative study Immigration detention Infectious diseases	Reports the prevalence of tuberculosis, hepatitis B carriage and markers of hepatitis C and HIV infection as detected through routine screening of asylum seekers arriving by boat in Australia. With the rates of such diseases being higher than the general Australian population, this highlights the importance of surveillance and appropriate treatment of diseases of public health importance, upon arrival.
Kisely, S. Stevens, M. Hart, B. Douglas, C.	2002	Health issues of asylum seekers and refugees	Australian & New Zealand Journal of Public Health: 26(1); 8-10	Literature review and policy discussion Community-residing asylum seekers Health care access	A discussion on the public health implications relating to asylum seeker policy. The author argues that the health of asylum seekers is compromised by a lack of social support, fragmented policy between state and federal governments, under-funded interpreter services and restrictions on work and health care rights of some visa classes. This has implications for both the individual, whose vulnerability to poor health exacerbates their problems, but also for the wider community.

AUTHORS		YEAR	TITLE	JOURNAL	PUBLICATION TYPE AND KEY WORDS	SUMMARY OF CONTENT
Koutroullis, G.		2003	Detained asylum seekers, health care, and questions of human(e)ness	Australian & New Zealand Journal of Public Health: 27(4); 381-4	Personal narrative Immigration detention Mental health	The author provides a personal reflection on immigration detention from her experience working there for 6 weeks as a psychiatric nurse. The author refers to the use of inappropriate language by the media and government to portray asylum seekers in a negative way. She argues that the self-harming is a physical manifestation of the frustration felt by detainees faced with an oppressive environment.
Lawrence, C.		2004	Mental illness in detained asylum seekers	Lancet: 364(9441); 1283-4	Letter to the editor Immigration Detention Mental health	The author (the then federal member for Freemantle) discusses the harmful effects of immigration detention on the mental and physical health of asylum seekers with reference to human rights and dignity. She urges other governments not to follow the same policy path as Australia.
Loff, B.		2002	Detention of asylum seekers in Australia	Lancet: 359(9308); 792-3	Commentary Immigration detention Health care access	The author argues there is no justification for the incarceration of a person for an indefinite period of time when they have committed no crime. She highlights some of the barriers to accessing health care within detention centres.
Mansouri, F. Cauchi, S.		2006	The psychological impact of extended temporary protection	Refuge: 23(2); 81-94	Qualitative study Temporary Protection Visas Mental health	The article explores the journey that asylum seekers take as a narrative with case examples. In particular, it discusses the implications of the Temporary Protection Visa and how the uncertainty of asylum seekers' status in Australia further exacerbate post-migration trauma. Through interviews with TPV holders, it was found that mental health was affecting every aspect of their lives, from community participation to learning English and securing employment.

AUTHORS	YEAR	TITLE	JOURNAL	PUBLICATION TYPE AND KEY WORDS	SUMMARY OF CONTENT
Mares, S. Newman, L. Dudley, M. Gale, F.	2002	Seeking refuge, losing hope	Australasian Psychiatry: 10(2);91-6	Observational study Immigration detention Mental health Parenting	Describes observations from visits to immigration detention centres at a time when children were detained with their families. Interviews reveal that mental health problems are exacerbated by the detention experience, which affects family relations. The researchers found that the parental role was undermined by the hostile detention environment, resulting in children being physically and emotionally neglected.
Mares, S. Jureidini, J.	2004	Psychiatric assessment of children and families in detention	Australian & New Zealand Journal of Public Health: 28(6); 520-6	Reporting quantitative data Immigration detention Mental health Children and families	Reports the results of assessments of children and their families referred to a mental health service from immigration detention. All of the children referred had at least one parent affect by mental illness: 87% of adults had major depression, 56% had PTSD, 25% had psychosis illness requiring hospitalisation and 31% had tried self-harming. Among even the youngest children, emotional and behavioural disorders were common and many had language and developmental delays. All of the children had witnessed graphic, disturbing events such as attempted suicides and self-harm, creating anxiety around their parents' well-being. Major depression, anxiety, suicidal ideation, PTSD and persistent somatic symptoms were highly prevalent among children.
Martin, F. Hutchinson, T.	2005	Mental health and human rights implications for unaccompanied minors seeking asylum in Australia	The Journal of Migration and Refugee Issues: 1(1); 1-24	Human rights and policy analysis Immigration detention Rights of the child	The authors discuss the obligations that Australia has to protect the rights of unaccompanied minors under international human rights frameworks. In particular they discuss mandatory detention and the long term effect on the mental health of vulnerable children.
McAndrew, M.	2004	Detention centres and the RANZP	Australasian Psychiatry: 12(10):84	Commentary Immigration detention Health Professionals	The author argues that the issue of mandatory detention is more complex than the psychological impact and that health professionals should tread with caution when raising their concerns about the issue without full understanding of the implications of the policy.



AUTHORS	YEAR	TITLE	JOURNAL	PUBLICATION TYPE AND KEY WORDS	SUMMARY OF CONTENT
McGorry, P.	2002	Asylum seeking and mandatory detention. The psychological consequences	Australian Family Physician: 31(3):275-8	Case studies and commentary Immigration detention Mental health	The author describes the conditions of detention centres and states that "medical and particularly psychiatric disorders are neglected, misdiagnosed and at times responded to punitively". He points out that asylum seekers in detention have experienced twice the level of war trauma as asylum seekers living in the community and the detention experience exacerbated this trauma further.
McNevin, A. Correa-Velez, I.	2006	Asylum seekers living in the community on Bridging Visa E: community sector's response to detrimental policies	Australian Journal of Social Issues: 41(1); 125-39	Policy analysis Community residing asylum seekers Bridging visas Community-based organisations	A discussion around the provision of services in the community sector to asylum seekers on bridging visas. The authors state that there is a high degree of commitment and interagency support, however many organisations are run with the support of volunteers and philanthropic donations, or small community grants. Although they cope as best they can with the growing numbers of asylum seekers, there are limitations to what their already-stretched resources can provide. Interestingly, the situation has not changed much since this paper was written, with the community sector supporting asylum seekers where policy and governmental assistance is lacking.
Mitchell, G. Kirsner, S.	2004	Asylum seekers living in the Australian community: a casework and reception approach, asylum seeker project, Hotham Mission, Melbourne	Refuge: 22(1): 119	Quantitative data and discussion of project approach Community residing asylum seekers Casework approach Policy	A descriptive example of a service model offered by Hotham Mission Asylum Seeker Project in Melbourne for asylum seekers living in the community. The authors discuss some of the relevant policy pertaining to this group with a particular focus on their housing, employment and health needs. Some results are reported from of a wider research project conducted by Hotham Mission, which is reported elsewhere in the grey literature. One section looks at the response taken by Hotham Mission with regards to clients who may be required to depart Australia due to a visa refusal.

AUTHORS	YEAR	TITLE	JOURNAL	PUBLICATION TYPE AND KEY WORDS	SUMMARY OF CONTENT
Mormartin, S. Steel, Z. Coello, M. Aroche, J. Silove, D. Brooks, R.	2006	A comparison of the mental health of refugees with temporary versus permanent protection visas.	Medical Journal of Australia: 185(7):357-61	Quantitative study Post migration risk factors Mental health Refugees*	Refugees attending an early intervention program at a torture and trauma service were asked to complete standardised measures of previous trauma, detention experiences, post migration stressors, symptoms of PTSD, anxiety, depression and functional impairment. It was demonstrated that Temporary Protection Visa (TPV) status was a strong predictor of anxiety, depression and PTSD. Additional stressors in Australia had an adverse effect on mental health outcomes.
Murray, S. Skull, S.	2005	Hurdles to health: immigrant and refugee health care in Australia	Australian Health Review: 29(1); 25-9	Literature review and discussion Community residing refugees and asylum seekers Health care access	Article identifies hurdles to accessing health care as including: financial barriers, cultural differences, lack of or inadequately trained interpreter services, language difficulties, an undertrained workforce, fear of authority due to visa issues. They discuss how policy impacts on these hurdles and could be changed to improve asylum seeker and refugee health status.
Newman, L. Dudley, M. Steel, Z.	2008b	Asylum, detention and mental health in Australia	Refugee Survey Quarterly: 27(3):110-127	Literature review and policy discussion Immigration detention Mental Health	Examines the negative impact of immigration detention policy on asylum seekers with a particular focus on psychological health. The changing nature of detention policy is highlighted through a historical framework. The authors highlight the findings of commissions of inquiry and summarise results from clinical research as evidence of harmful effects of the policy. The authors urge health professionals and others to unite through advocacy.
Newman, L. Lightfoot, T. Aroche, J. Yong, C. Eagar, S. Gordon, A. Kotala, P. Whelan, A. Whittaker, M.	2010	Mental illness in Australian immigration detention centres	Lancet: 375(9723):1344-5	Letter to the editor Immigration detention Policy	Response to previous editorial. Mentions the changes made to immigration policy since 2006, including reductions in numbers of detained asylum seekers including children, shorter processing times and the introduction of "Detention Health Standards".



AUTHORS	YEAR	TITLE	JOURNAL	PUBLICATION TYPE AND KEY WORDS	SUMMARY OF CONTENT
Newman, L. Steel, Z.	2008	The child asylum seeker: Psychological and developmental impact of immigration detention	Child and Adolescent Psychiatric Clinics of North America: 17; 665-83	Literature review and policy discussion Immigration detention Mental health Children	A review of the literature and policy that frames the debate around children and unaccompanied minors in immigration detention. The findings of commissions of enquiry and empirical research are used to highlight the harmful impact immigration detention has on the mental health, wellbeing and development of children using case studies to highlight examples. The authors acknowledge the challenge for clinicians trying to manage distress in the context of re-traumatisation in the detention environment. They assert that clinicians responsible for the care of children should always advocate for their needs and act in the best interest of the child.
Nickerson, A. Steel, Z. Bryant, R. Brooks, R. Silove, D.	2011	Change in visa status amongst Mandaeen refugees: relationship to psychological symptoms and living difficulties	Psychiatry Research: 187(1-2); 267-74	Quantitative study Visa status Refugees* Mental health	Reports the findings of two surveys conducted over a 3 year period to assess the impact of visa status change on the mental health of refugees. Significant improvements in PTSD, depression symptoms and improvements in mental health-related quality of life were observed in relation to changing from a temporary to a permanent visa. The authors argue it is likely that restriction of rights and access to services due to visa status has a negative impact on the mental health of refugees.
O'Reilly, S. O'Shea, T. Bhusumane, S.	2012	Nutritional Vulnerability Seen Within Asylum Seekers in Australia	Journal of Immigrant & Minority Health: 14(2); 356-60	Quantitative study Community residing asylum seekers Food insecurity	An audit of the use of the Asylum Seeker Resource Centre's food bank in Melbourne, which around 350 people access every month. This study found that asylum seekers were food insecure and unable to meet the standard nutritional requirements, which has implications for their health, particularly chronic disease.
Phillips, C.	2010	Immigration detention and health	Medical Journal of Australia: 192(2); 61-2	Editorial Immigration detention Policy	An overview of immigration detention policy in light of the publication by Green & Eagar (2010) on medical records of asylum seekers in Australian detention centres. The author welcomes the increased transparency of the government and advocates for immigration detention to be used as a last resort, considering the findings of the publication.
Phillips, C. Smith, M. Kay, M. Casey, S.	2011	The Refugee Health Network of Australia: towards national collaboration on health care for refugees	Medical Journal of Australia: 195(4); 185-6	Editorial Community residing refugees and asylum seekers Health issues	An introduction to refugee health issues and the role of the Refugee Health Network of Australia. The author points out that refugee health issues are constantly evolving and health practitioners need to continually update their knowledge of diseases and cultural practices common in those countries in order to provide the most appropriate care.

AUTHORS	YEAR	TITLE	JOURNAL	PUBLICATION TYPE AND KEY WORDS	SUMMARY OF CONTENT
Procter, N.	2005	They first killed his heart (then) he took his own life'. Part 1: A review of the context and literature on mental health issues for refugees and asylum seekers	International Journal of Nursing Practice: 11(6); 286-91	Literature review and policy discussion Community residing refugees and asylum seekers Mental health	A discussion paper exploring issues around asylum seekers and mental health including implications on memory and recall, suicide and self-harm risk. For example, the author argues that trust between asylum seekers and service providers can be difficult to build in the context of the immigration process when some asylum seekers' claims are being questioned by officials. It looks at some of the mental health risk and protective factors for both child and adult asylum seekers and emphasises the importance of culturally-appropriate care.
Procter, N.	2005b	A call for deeper scrutiny of mental health care for people in Australian immigration detention centres	International Journal of Mental Health Nursing: 14(2); 70-1	Editorial Immigration detention Visa process Mental health	A discussion on the provision of mental health care for asylum seekers in immigration detention. The author questions whether mental health care can be facilitated in a detention centre when trust, a safe and predictable environment are such integral parts of effective assessment and treatment. The process of claiming asylum is traumatic in itself, and possibly further exacerbated their mental distress. The author suggests providing integrated mental health services that are evidence-based, culturally appropriate, emphasise prevention and promote well-being, and are open to monitoring and evaluation in order to inform best practice.
Procter, N.	2004	Emergency mental health nursing for refugees and asylum seekers	Australian Nursing Journal: 12(6); 21-3	Informative Mental health Emergency care	An informative account of the mental health care needs of refugees on Temporary Protection Visas and how emergency nurses faced with distressed asylum seekers and refugees can develop strategies to respond appropriately. Self-harm and suicide attempts are more likely to occur in the context of visa rejection. The author makes recommendations around provision of care in emergency departments.
Procter, N.	2004b	The mental health of moving asylum seekers from 'temporary' to 'permanent' protection visas: it's much more than a quick political fix	Contemporary Nurse: 17(3); 179-82	Editorial Visa status Mental health Immigration policy	The author discusses the problems associated with the Temporary Protection Visa policy and makes suggestions about how the system and approach to the mental health of asylum seekers could be improved to better provide for their needs. One indirect strategy is to draw upon the examples of the community and volunteer sector who have built trusting relationships with asylum seekers. It is also emphasised that there is a need to communicate immigration policy with clarity and certainty to alleviate the confusion and fear around the visa process.

AUTHORS	YEAR	TITLE	JOURNAL	PUBLICATION TYPE AND KEY WORDS	SUMMARY OF CONTENT
Procter, N.	2006b	'They first killed his heart (then) he took his own life': Part 2: Practice implications	International Journal of Nursing Practice: 12(1): 42-8	Informative Mental health services Culturally competent care	A follow up to the 2005 article, the author explores some of the ways in which mental health services can be designed to improve access, coordination and continuity of care, for example through the implementation of care pathways and case management. Asylum seekers may be fearful of a mental health diagnosis for a number of reasons including fear of stigmatisation and subsequent loss of employment, affect on immigration decisions, or involuntary hospitalisations. Appreciation and understanding of cultural beliefs and how they influence the communication of health problems, symptoms, and help-seeking behaviour, are integral to the successful engagement of patients from ethnically diverse backgrounds.
Rees, S.	2003	Refuge or retrauma? The impact of asylum seeker status on the wellbeing of East Timorese women asylum seekers residing in the Australian community	Australasian Psychiatry: 11(1s): 96-191	Qualitative and quantitative study Visa status Mental health	The author discusses the findings from semi-structured interviews with East Timorese women asylum seekers living in the community and questionnaires from service providers. The threat of forced removal from Australia was associated with fear and trauma, resulting in sleep disturbance, intrusive thoughts, loss of motivation, loss of self-esteem and anger. Some reported their levels of stress were so high they became unwell. The service providers agreed that the effects of past torture and trauma combined with an undetermined immigration status resulted in ongoing fear, anxiety and physical illness.
Robjant, K. Hassan, R. Katona, C.	2009	Mental health implications of detaining asylum seekers: systematic review	British Journal of Psychiatry: 194(4): 306-12	Systematic literature review Research Immigration detention Mental health	This systematic literature review assesses the impact of immigration detention on the mental health of asylum seekers in the UK, USA and Australia. The international data support the findings from Australian studies and consistently demonstrates high rates of depression, anxiety, PTSD, self-harming and suicidal ideation as well as lower prevalence rates of psychosis in asylum seekers who were, or have been detained. The systematic review found that worse outcomes are associated with longer periods of time in detention. The authors compare the strengths and weaknesses of the studies and discuss ethical and practical considerations of conducting research with asylum seekers.

AUTHORS	YEAR	TITLE	JOURNAL	PUBLICATION TYPE AND KEY WORDS	SUMMARY OF CONTENT
Ryan, K.	2011	Mental health care for exploring detainees: a fundamental recovery human right	Australian Nursing Journal: 19(4); 37	Commentary Immigration detention Mental health services	A brief discussion of the challenges and ethical dilemmas faced by health professionals working in immigration detention centres and calls for the provision of better mental health services for the benefit of not only asylum seekers, but the whole Australian community.
Shaw, M. Leggat, P.	2006	Medical screening and the health of illegal immigrants in Australia	Travel Medicine and Infectious Disease: 4(5); 255-8	Editorial Immigration detention Health assessment Infectious diseases	A discussion of the health needs of detained asylum seekers. The authors argue that the policy of detaining asylum seekers arriving by boat raises concerns about the potential importation of infectious diseases and subsequent need for disease awareness and screening. The authors state that some asylum seekers are likely to be suffering from acute conditions related to the nature of their journey to Australia, including injuries, dehydration and psychological trauma; while the detention environment may attribute other physical conditions.
Sheikh, M. Macintyre, C. Perera, S.	2008	Preventive detention: the ethical ground where politics and health meet. Focus on asylum seekers in Australia	Journal of Epidemiology and Community Health:62(6); 480-3	Policy analysis Immigration detention Human rights	An in-depth discussion of the immigration detention policy with a detailed historical perspective and comparison. The authors argue that the issue of health in immigration detention should be considered in light of political, historical and social contexts. They urge health professionals to advocate on behalf of asylum seekers whose human rights are being abused by the current system.
Silove, D.	2002	The asylum debacle in Australia: a challenge for psychiatry	Australian and New Zealand Journal of Psychiatry:36(3); 290-6	Literature review and policy discussion Post migration risk factors Mental health Psychiatry	A historical and political perspective on the policies that affect the mental health of asylum seekers post-migration in Australia. The author encourages psychiatrists to become involved in order to protect the rights of this vulnerable group by advocating as a professional group and assisting with clinical consultation, research, report writing and other tasks which draw attention to public policies which undermine the mental health needs of asylum seekers.

AUTHORS	YEAR	TITLE	JOURNAL	PUBLICATION TYPE AND KEY WORDS	SUMMARY OF CONTENT
Silove, D. Coello, M. Tang, K. Aroche, J. Soares, M. Lingam, R. Chaussivert, M. Manicavasagar, V. Steel, Z.	2002	Towards a researcher-advocacy model for asylum seekers: A pilot study amongst East Timorese living in Australia	Transcultural Psychiatry: 39(4); 452-68	Qualitative and quantitative study Community residing asylum seekers Mental health Research methodology	Through a unique integrated model, East Timorese asylum seekers participated in a study involving qualitative, quantitative methods, advocacy and strategic assistance. The findings revealed high levels of trauma, psychiatric disorders and settlement issues. The author discusses some of the practical and ethical challenges associated with conducting research including recruitment challenges, language and interpreter issues as well as the potential for re-traumatisation. The author highlights the importance of the research group being actively involved with the asylum seeker population prior to commencing research in order to reduce the risk of being intrusive and to ensure the population group are actively involved and benefit from the process.
Silove, D. Austin, P. Steel, Z.	2007	No refuge from terror: the impact of detention on the mental health of trauma-affected refugees seeking asylum in Australia	Transcultural Psychiatry:44(3); 359-93	Literature review and policy discussion Immigration detention Mental health	The authors draw upon a range of sources of information including studies, Commissions of Inquiry and first hand accounts from mental health professionals to demonstrate the impact that prolonged, mandatory detention has on the mental health of asylum seekers. The authors argue that this evidence from Australia should encourage those in other countries to remain vigilant in upholding the human rights of asylum seekers.
Silove, D. Steel, Z. McGorry, P. Miles, V. Drobny, J.	2002	The impact of torture on post-traumatic stress symptoms in war-affected Tamil refugees and immigrants	Comprehensive Psychiatry:43(1); 49-55	Qualitative Study Community residing refugees and asylum seekers Torture and trauma Mental health	This study examined the effect of torture in generating post-traumatic stress disorder (PTSD) symptoms with comparison to other traumas suffered by a war-affected sample of Tamils in the community (refugees, asylum seekers and voluntary immigrants). Tamils exposed to torture were found to have higher PTSD scores than other war trauma survivors after controlling for overall levels of trauma exposure.
Smith, M.	2000	Desperately seeking asylum: the plight of asylum seekers in Australia	New Doctor: 74; 21-3	Informative Community residing asylum seekers Health care access	An informative article on immigration policy and the health risks of asylum seekers. The author describes asylum seekers as one of the most vulnerable, disadvantaged population groups in Australia, yet policy limits access to important services despite their needs. Much of the policy discussed has changes but the impact is still relevant today.



AUTHORS	YEAR	TITLE	JOURNAL	PUBLICATION TYPE AND KEY WORDS	SUMMARY OF CONTENT
Spike, E. Smith, M. Harris, M.	2011	Access to primary health care services by community-based asylum seekers	Medical Journal of Australia: 195(4); 188-91	Qualitative Study  Community residing asylum seekers Health care access Post migration stressors	Interviews conducted with asylum seekers and service providers in NSW. Fees, lack of information, delays in getting appointment, lack of choice, inadequate time with doctor, lack of interpreter were identified by asylum seekers as barriers to accessing health care. Health care service providers found difficulties negotiating pro-bono services a problem and thought lack of support and the psychological vulnerability made asylum seekers reluctant to seek out services. Difficulties accessing health care contributed to stress and anxiety experienced by asylum seekers. Other stressors included: undetermined immigration status, financial stress, housing insecurity, social isolation, separation from family and the inability to work.
Steel, Z. Chey, T. Silove, D. Marmane, C. Bryant, R. Van Ommeren, M.	2009	Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis	Journal of the American Medical Association: 302(5); 537-49	Systematic review and meta-analysis  Refugees and asylum seekers Torture and trauma Mental health	The systematic review and meta-analysis revealed that torture is the strongest substantive factor associated with PTSD, while cumulative exposure to potentially traumatic events is the strongest substantive factor associated with depression. This has implications for understanding the level of PTSD and depression in the asylum seeker and refugee community who report high levels of torture and trauma.
Steel, Z. Frommer, N. Silove, D.	2004	Part I--The Mental Health Impacts of Migration: The Law and Its Effects Failing to Understand: Refugee Determination and the Traumatized Applicant	International Journal of Law and Psychiatry: 27(6); 511-28	Case studies, legal and psychological analysis  Visa process Mental health	A legal and psychological perspective on the process of refugee determination for asylum seekers. The interesting point to note here is that people who have suffered trauma will not all express psychological distress in the same way, yet this may have an effect on the outcome of their application.

AUTHORS	YEAR	TITLE	JOURNAL	PUBLICATION TYPE AND KEY WORDS	SUMMARY OF CONTENT
Steel, Z. Momartin, S. Bateman, C. Hafshejani, A. Silove, D. Everson, N. Roy, K. Dudley, M. Newman, L. Blick, B. Mares, S.	2004	Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia	Australian and New Zealand Journal of Public Health: 28(6); 527-36	Quantitative study - psychiatric assessment Immigration detention Mental health Children and families	Interviews with asylum seekers families in prolonged detention were conducted in order to determine the degree of psychological suffering experienced by detainees. Self-harm, attempted suicide and hunger strikes were commonly witnessed events. Assessment by psychologists revealed that all asylum seeker adults interviewed suffered from major depressive disorder and most met the criteria for PTSD. Suicidal ideation was experienced by nearly all adults and a third had tried self-harming. All children received a diagnosis of at least one psychiatric condition. For adults there was a three-fold increase in psychiatric disorder, and for children a 10-fold increase, since being detained in an immigration centre. Also discusses access to health care in detention.
Steel, Z. Momartin, S. Silove, D. Coello, M. Aroche, J. Tay, K.	2011	Two year psychosocial and mental health outcomes for refugees subjected to restrictive or supportive immigration policies	Social Science and Medicine: 72(7); 1149-56	Quantitative study Community residing refugees* Visa status Mental health	A two-year follow up study of refugees from Afghanistan and Iran that examines psychological symptoms and social adaptation among temporary and permanent protection visa holders. The findings showed that TPVs had higher baseline levels of depression, anxiety and overall distress, which increased over time. They were also found to have more settlement difficulties, poorer acquisition of English language skills and greater social isolation, which led the authors to suggest that restrictive policies on visa holders lead to poorer health and other outcomes.
Steel, Z. Silove, D. Brooks, R. Momartin, S. Alzuhairi, B. Suslijk, I.	2006	Impact of immigration detention and temporary protection on the mental health of refugees	British Journal of Psychiatry: 188; 58-64	Quantitative study Community residing refugees* Visa status Mental health	In this study, Mandeian refugees in Sydney were interviewed and assessed for post-traumatic stress disorder (PTSD), major depressive episodes, and indices of stress related to past trauma, detention and temporary protection. The authors found that previous experiences of mandatory detention and temporary protection visas independently contributed to mental health disorders. The length of time in detention was a significant contributor; the effects of which persisted a number of years after release.



AUTHORS	YEAR	TITLE	JOURNAL	PUBLICATION TYPE AND KEY WORDS	SUMMARY OF CONTENT
Sultan, A. O'Sullivan, K.	2001	Psychological disturbances in asylum seekers held in long term detention: a participant-observer account	Medical Journal of Australia: 175(11-12); 593-6	Personal narrative and policy discussion Immigration detention Mental health	An 'insider's perspective' of immigration detention written by a medical practitioner who fled Iraq and was subsequently detained. He gives a personal account of life inside the centre and reports the results of a semi-structured interview with 33 asylum seekers who had been detained for more than 9 months. All but one participant displayed symptoms of psychological distress, with 85% expressing chronic depressive symptoms and over two-thirds reporting suicidal ideation. A few (7) were observed to have signs of psychosis but had not yet received appropriate care. Sultan describes the progression of mental health decline in a series of stages which relate to both time spent in detention and outcome of immigration decision.
Sweet, M.	2007	Call for action on asylum seekers' health	Australian Nursing Journal: 14(9); 16-18	Informative Community residing and detained asylum seekers Health care services Health professionals	A journalistic-style article with quotes from staff at the Asylum Seeker Resource Centre, Louise Newman, Deborah Zion, Zachary Steel and Nicholas Procter. It discusses the difficulties some asylum seekers have in accessing health services due to Medicare ineligibility and the subsequent need for ASRC staff to negotiate and advocate for fee-waivers for these patients. It also looks at the difficulties faced by nurses working in immigration detention centres as well as highlighting some of the more positive recent changes made to legislation concerning immigration detention.
Thomas, S. Douglas, P. Smith, M.	2010	Bug Breakfast in the Bulletin: refugee health	New South Wales Public Health Bulletin: 21(3-4):101-2	Informative Community-residing refugees and asylum seekers Health conditions Health care access	Informative article discussing health issues relevant to refugees and asylum seekers such as pre-department health screening requirements and common health conditions in children and adults. Health service access barriers include: language, cultural barriers, knowledge of services, transport and service costs, most notably for specialist, dental, and allied health care and medications. The authors state that guidelines and training might assist some health professionals to be more culturally sensitive and provide better quality care to asylum seekers.
Zion, D.	2004	Caring for detained asylum seekers, human rights and bioethics	Australian and New Zealand Journal of Public Health: 28(6):510-12	Editorial Immigration detention Health professionals Ethical standards	A bioethical analysis of the dilemmas faced by health workers in immigration detention centres. The author asserts that some health care workers face a conflict between their duty of care to a patient and obligations to uphold the interests of a third party, usually their employer. She states collective action from professional bodies might be more successful and reduce the burden placed on individuals advocating for asylum seekers.

# Appendix C: Asylum seeker services Melbourne

## Primary care services

### Asylum Seeker Resource Centre Health Centre

The Asylum Seeker Resource Centre (ASRC) operates a health centre on weekdays. Due to high service demand, the clinic is limited to asylum seekers without Medicare and those not receiving ASAS payments.

In terms of health care staff they have a:

- Full time coordinator
- Registered nurse 2 days per week
- Community health nurse 3 days per week
- GP volunteers
- Around 20 other health care volunteers

The clinic provides comprehensive health care assistance to asylum seekers including:

- Triage and assessment
- General nursing care
- Medical assessment
- Medico-legal reports
- External or internal referral
- Vaccinations
- Pharmaceuticals
- Physiotherapy
- Diabetes education
- Complementary therapies
- Health promotion and education
- Patient advocacy

Current challenges for ASRC Health Clinic:

- The cost of pharmaceuticals is a huge burden on their limited finances – some clients are on a number of medications concurrently. ASRC are receiving some support from local pharmacies to keep costs low, but this area remains an ongoing challenge.
- According to staff involved in the clinic, the reliance on volunteers can make it difficult to ensure knowledge is shared as required.
- They rely on pro-bono service providers in the community for imaging and pathology; most notably CMMI through St Vincent's, which provides a majority of client imaging needs; and St John of God Pathology, through pro-bono arrangements. ASRC is continuing to arrange secure referral pathways to ensure this is sustainable.
- Health equipment, such as diabetes glucose monitors or spectacles can be difficult to cover costs for, but ASRC remain committed to reducing the financial burden on asylum seekers.

- Staff are required to undertake advocacy and negotiation to have fees waived for some other referral services, such as specialists or allied health.

### **Southern Health refugee health services**

Southern Health has a well-established refugee health service that operates at both primary and tertiary levels. It is an integrated, comprehensive service that specialises in caring for the complex needs of refugees and asylum seekers in the South Eastern suburbs of Melbourne. The primary care service is described here; the tertiary level service is described further below.

### **Cardinia Casey Asylum Seekers and Refugee Health Clinic**

The Cardinia Casey Asylum Seekers and Refugee Health Clinic or 'Doveton Clinic' was established in April 2011 specifically to cater for asylum seekers and refugees due to growing numbers settling in the South-East. The clinic offers comprehensive, integrated services across the spectrum of care and prioritises patients with complex health needs and compromised health entitlements. The clinic runs on weekdays and is supported by:

- Two General Practitioners
- Four refugee health nurses
- A psychiatry fellow and psychiatrist
- A bicultural worker
- Onsite interpreters
- Multidisciplinary allied health team (in particular physio and counselling)
- Pathology service
- Full time administrative staff

The clinic model has been highly successful in reducing barriers for clients and meeting high service demands. This is partly due to:

- Salaried General Practitioners
- A demand management schedule
- Assisted pathways for allied health, psychiatry and other specialists
- Pathology and imaging services supported by Southern Health
- Orientation and training of staff to ensure they are well informed about the unique needs of asylum seekers and refugees
- Clinical guidance and supervision of staff
- Strong ties with other agencies providing assistance to asylum seekers

Southern Health continues to show its commitment to addressing the needs of asylum seekers through ongoing strategic planning and collaboration with the South East Medicare Local to up-skill and support the local GP community. They play an active role in the Health Orientation and Triage sessions with BVE holders, run in collaboration with Red Cross. The aim of this initiative is to 'triage' clients into services best suited to cater for their needs, depending on the complexity or risks associated with identified health conditions. This would ensure that low-risk patients can be managed by a community GP, while those with more complex needs are referred to Southern Health clinics or the emergency department.

### **The Victorian Refugee Health Nurse Program (RHNP)**

This program is delivered by nurses in community health centres across the state in 20 Local Government Areas. The nurses have undergone training in provision of services to culturally and linguistically diverse groups and have been integral to the refugee and asylum seeker health sector. The RHNP operates in areas where

there are a greater proportion of refugees and asylum seekers. There are currently around 27 refugee health nurses dispersed across Victoria. In general, the nurses work with multidisciplinary teams within community health centres (CHC). The role of the RHNP is to facilitate:

- Intake assessments
- Initial health screening
- Referral to GPs and specialists
- Health education
- Case management
- Patient advocacy
- Support and education to other local service providers

Table 30 shows where the program is operating in metropolitan Melbourne.

**Table 30: Refugee Health Nurse Program locations, Melbourne**

AGENCY	LOCAL GOVERNMENT AREA	WEBSITE
Southern Health - Casey Cardinia CHC	Greater Dandenong	<a href="http://www.southernhealth.org.au">www.southernhealth.org.au</a>
Southern Health - Dandenong CHC	Greater Dandenong	<a href="http://www.southernhealth.org.au">www.southernhealth.org.au</a>
Darebin CHC	Darebin	<a href="http://www.dch.org.au">www.dch.org.au</a>
Dianella CHC	Hume	<a href="http://www.dianella.org.au">www.dianella.org.au</a>
Doutta Galla CHC	Mooney Valley/ Melbourne	<a href="http://www.doutta.org.au">www.doutta.org.au</a>
ISIS Primary Care - Brimbank	Brimbank	<a href="http://www.isispc.com.au">www.isispc.com.au</a>
ISIS Primary Care - Wyndham	Wyndham	<a href="http://www.isispc.com.au">www.isispc.com.au</a>
Maroondah Eastern Access Community Health (EACH)	Maroondah	<a href="http://www.each.com.au">www.each.com.au</a>
Western Region Health Centre - Braybrook	Maribrynong	<a href="http://www.wrhc.com.au">www.wrhc.com.au</a>
Western Region Health Centre - Footscray	Maribrynong	<a href="http://www.wrhc.com.au">www.wrhc.com.au</a>

### Other primary care service providers

There are a number of other primary care practices which are known for their willingness to provide health care for asylum seekers, such as those identified above where the Refugee Health Nurses are based or some refugee health services are offered, such as Vitamin D treatment, infectious diseases, community mental health or paediatrics. These include:

- Western Region Health Centre
- ISIS Primary Care
- Darebin Community Health Centre
- Dianella
- Doutta Galla Community Health Centre

- Eastern Access Community Health
- North Yarra Community Health

Their capacity to support asylum seekers without Medicare is likely to fluctuate with service demand from the general community. In addition to these clinics which cater for refugees, referrals for primary care also rely on ad-hoc arrangements with particular individuals who have some knowledge of refugee health issues.

## Specialist health services in tertiary settings

### Refugee Health Fellows Program

The Refugee Health Fellows program has been established for medical professionals with an interest in refugee health. The program provides a bridge between primary and tertiary care for refugees, with fellows also providing support and strengthening the capacity of regional service providers. They provide specialist consultation, management and treatment of conditions such as hepatitis B, tuberculosis, parasite screening, vitamin D deficiency, immunisation catch-up and nutritional deficiency in an outpatient capacity. In addition, the clinics are central points for research, education and training. In 2013, the Victorian Department of Health is supporting two Refugee Health Fellows at the Victorian Infectious Disease Service (VIDS) Immigrant and Refugee Clinic at the Royal Melbourne Hospital.

### Immigrant Health Service, The Royal Children's Hospital

The Immigrant Health Service at Royal Children's Hospital runs a weekly outpatient clinic for refugee children. The service provides assessment and consultation with a multidisciplinary team with the support of onsite interpreters. Key health concerns centre on immunisation, infectious disease screening, nutritional disorders, dental health and child development. Staff are actively involved in research, education, training and the development of clinical guidelines.

### VIDS Immigrant and Refugee Clinic, Royal Melbourne Hospital

The Victorian Infectious Disease Service (VIDS) Immigrant and Refugee Clinic specialise in caring for people with infectious diseases such as HIV/AIDS, hepatitis, tuberculosis and nutritional deficiencies. The clinic runs once per week at the Royal Melbourne Hospital. Staff regularly participate in research and consult on immigrant health issues with the wider health community.

### Dandenong Hospital Outpatient Refugee Clinic

This tertiary level service provides a range of services to refugees and asylum seekers including infectious diseases, psychiatric care and maternal and child health.

The clinic runs weekly and is supported by:

- Two infectious diseases physicians
- A paediatrician and paediatric fellow
- A pharmacist
- A refugee health worker

Through Southern Health, asylum seekers can get at-cost medication and access to interpreters. The pharmacy service is familiar with refugee health issues and stocks appropriate medications.

## Mental health services

### The Victorian Foundation for Survivors of Torture

The Victorian Foundation for Survivors of Torture (VFST; more commonly known as Foundation House), is the key service provider in Victoria for adults and children who have experienced torture, persecution or war-related trauma prior to arriving in Australia. They have a number of programs and operations running across offices in Brunswick, Dandenong, Ringwood and Sunshine including:

- Individual and family counselling services
- Group support sessions
- Health promotion
- Family and community strengthening
- Assistance, advice and referral for resettlement and orientation issues such as finding housing, employment, education and social activities
- Advocacy and assistance in navigating Australia's health system
- Training programs for organisations and individuals providing services for refugees and asylum seekers
- Traditional medicine and complementary therapies
- Preparation of policy documentation and submissions to government
- Development of education resources

All of Foundation House's services are offered to asylum seekers, regardless of Medicare eligibility. Due to high service demand, long waiting lists and inappropriate referrals, it is necessary to conduct intake assessments. According to intake staff at Foundation House, prioritisation of clients involves assessing them for the following criteria:

- History of torture
- Identified as having severe depression, suicide or self-harm
- In Australia for less than 3 months
- Minors

Foundation House have also partnered with the Victorian Transcultural Psychiatry Unit through the Refugee Mental Health Program. Clinics have been established in Brunswick and Dandenong with the support of a network of private mental health practitioners who provide sessional mental health services to refugees and asylum seekers at no cost. These GPs, psychologists and psychiatrists all receive training in refugee mental health intervention. Asylum seekers without Medicare are not restricted from services but this will affect funding arrangements. The Counsellor-Advocate program is more appropriate for asylum seekers due to their need for complex social support and orientation during the visa determination process. Foundation House also receive some government funding to care for community detention clients who are referred to their mental health clinic.

### Asylum Seeker Resource Centre

In addition to a health clinic, the ASRC also run two mental health programs. The service consists of a specialist psychiatry out-patient clinic provided by volunteer psychiatrists. This is complemented by a large counselling program which is run by both volunteer and some paid psychologists and counsellors. Due to high service demand, clients are prioritised based on need. They do not currently care for clients who are in community detention programs.

## ASRC Counselling Program

The ASRC Counselling program provides specialist pro-bono counselling and mental health services for asylum seekers who are experiencing high levels of psychological distress. All staff receive ongoing training, professional supervision and de-briefing. The counselling program operates all week days and includes:

- Assessment and counselling for individuals
- Support for clients through visa-related issues
- Recreational programs for families, children and adolescents
- Report writing to support refugee claims and funding applications
- Referrals to Foundation House for eligible clients

## ASRC Psychiatry Program

Since 2001, a psychiatric service, run by volunteer psychiatrists has been providing assessment and treatment to asylum seekers. It operates on weekdays and Saturday morning and any given time, this team is treating 40-50 patients. There can be a waiting list to see a psychiatrist but continuity of care is ensured – some patients may be seen for 12-24 months. Both programs are limited by their reliance on volunteers. They do not have the capacity to systematically screen clients attending the ASRC, nor meet the demands of all asylum seekers requiring intervention. The staff mix in the counselling program requires supervision and support of more junior staff. Furthermore, they do not currently care for clients in the community detention program.

## Cardinia Casey Asylum Seekers and Refugee Health Clinic

Counselling is offered to people of refugee backgrounds as part of the refugee and asylum seeker health clinic. Staff are educated and trained in providing culturally sensitive care and can refer acute mental health needs to the psychiatry service within the clinic.

## Brotherhood of St Laurence: Counselling

The Ecumenical Migration Centre, Brotherhood of St Laurence offer a program of assistance to asylum seeker families which includes individual or family counselling with additional case work support.

*There are likely to be many other mainstream mental health services that have cared for asylum seekers through counselling or psychiatry programs. Further consultation is required to scope these services.*

## Non-Health Services

In Melbourne, there are a large number of not-for-profit organisations providing a wide variety of services to asylum seekers in the community. Many organisations have formal or informal case worker programs. The range of services provided can vary and may fluctuate depending on available funding sources. The following table is an outline of these services. More information can be found by visiting the website or contacting the organisation directly.



MELBOURNE COMMUNITY-BASED ASYLUM SEEKER SUPPORT SERVICES

CONTACT/LOCATION	REFERRAL TO HEALTH SERVICES	CASE WORK SUPPORT	FINANCIAL ASSISTANCE	ACCOMMODATION HOUSING	MATERIAL ASSISTANCE	LEGAL ADVICE	EMPLOYMENT ASSISTANCE	GENERAL INFORMATION & SUPPORT	SKILLS TRAINING EG. COMPUTER CLASSES	ADVOCACY, RESEARCH OR PUBLICATIONS	OTHER SERVICES
Asylum Seeker Resource Centre 12 Batman St West Melbourne 03 9326 6066 www.asrc.org.au	✓	✓		✓	✓	✓	✓	✓	✓	✓	Complementary therapies Food bank Internet access Recreational activities
Hotham Mission Asylum Seeker Project 2/579 Queensberry Street North Melbourne 03 9326 8343 www.hothammission.org.au		✓	✓	✓	✓		✓	✓	✓	✓	Community detention program
Victorian Foundation for Survivors of Torture (VFST) or 'Foundation House' 6 Gardiner St Brunswick 03 9388 0022 www.foundationhouse.org.au	✓						✓	✓	✓	✓	Complementary therapies.
The Ecumenical Migration Centre (EMC), Brotherhood of St Laurence 123 Brunswick Street Fitzroy 03 8412 8700 www.bsl.org.au/emc		✓					✓	✓	✓	✓	Phone and computer access

<b>OTHER SERVICES</b>	Recreational activities				
<b>ADVOCACY, RESEARCH OR PUBLICATIONS</b>				✓	✓
<b>SKILLS TRAINING EG. COMPUTER CLASSES</b>	✓	✓	✓		
<b>GENERAL INFORMATION &amp; SUPPORT</b>	✓	✓	✓	✓	✓
<b>EMPLOYMENT ASSISTANCE</b>		✓			✓
<b>LEGAL ADVICE</b>					
<b>MATERIAL ASSISTANCE</b>	✓				✓
<b>ACCOMMODATION HOUSING</b>	✓			✓	
<b>FINANCIAL ASSISTANCE</b>				✓	
<b>CASE WORK SUPPORT</b>		✓			
<b>REFERRAL TO HEALTH SERVICES</b>		✓			
<b>CONTACT/LOCATION</b>	25 Norwood Crescent Moonee Ponds 03 8480 9006 www.baptcare.org.au/ community-projects/ Pages/Supported- accommodation-for- asylum-seekers.aspx	198 Napier Street Fitzroy 03 9417 2897 www. fitzroylearningnetwork. org.au	Sydney Rd Brunswick 03 9388 2459 www.aswc.org.au	52 Beaconsfield Pde Albert Park 03 9696 2107 www.brigdineasp.org.au	7 Amberley Way Lower Plenty 03 94398282 www.erasp.org.au
	Baptcare Sanctuary	Fitzroy Learning Network	Asylum Seekers Welcome Centre	Brigline Asylum Seeker Project	1 Edmund Rice Asylum Seeker Project and 2 Br Noonan Asylum Seeker House of Welcome

OTHER SERVICES					
ADVOCACY, RESEARCH OR PUBLICATIONS					
SKILLS TRAINING EG. COMPUTER CLASSES					
GENERAL INFORMATION & SUPPORT	✓	✓	✓	✓	
EMPLOYMENT ASSISTANCE					
LEGAL ADVICE					✓
MATERIAL ASSISTANCE	✓	✓	✓	✓	
ACCOMMODATION HOUSING	✓		✓		
FINANCIAL ASSISTANCE					
CASE WORK SUPPORT					
REFERRAL TO HEALTH SERVICES					
CONTACT/LOCATION	16 Tinning Street Brunswick 03 9384 8333 www.salvationarmy.org.au/about-us_65047/services/migrant-services.html	333 Swanston St Melbourne 03 9623 9199 Admin@crossculture.org.au	118 Commercial Road Footscray 03 9680 8444 www.wesley.org.au	Level 1 Hub Arcade 1/26 McCrae St Dandenong 0409 416 744	121-123 Brunswick St Fitzroy 03 9413 0101 www.rilc.org.au
	Salvation Army Asylum Seeker Support Services	Swanston St Asylum Seeker Centre	Wesley Mission Support Service	Asylum Seekers Centre Dandenong	Refugee Immigration Legal Centre (RILC)

# Appendix D: Asylum seeker services Sydney

## Primary care services

### NSW Refugee Health Service

The NSW Refugee Health Service (RHS) was established in 1999 by the NSW Department of Health to cater for refugees settling in Sydney's western suburbs. The comprehensive, multi-disciplinary clinics are designed to support the health and wellbeing of refugees and asylum seekers and provide many patients with an initial contact with the health system. All consultations are free, interpreters are provided and clients without Medicare can access them. The service involves:

- Nursing intake assessments for newly arrived refugees, as well as asylum seekers living in the community
- Medical assessments within the service and referrals to local community services
- Targeted health promotion
- Referral to specialists or allied health
- Patient advocacy
- Policy development, advocacy and research in refugee health
- Education and consultation to health service providers on refugee health issues
- Collaboration with other multicultural health services and area health services

The General Practice clinics operate on a once per week or monthly basis in Auburn, Blacktown, Liverpool, Fairfield and Mt Druitt.

With increased funding provided by the NSW Department of Health, the NSW RHS has expanded its Refugee Health Nurse Program which now employs the equivalent of 8 full time nurses. The program operates at 10 different locations across Metropolitan Sydney. The nurses often have to work outside of the usual model of care to meet the needs of this client group, including addressing settlement issues.

In general, a demand management schedule is not required for the RHS although the nurses will try to prioritise patients based on their clinical needs. The NSW RHS has recently (March 2013) noticed an increase in the number of asylum seekers attending the service.

At times, there can be a 5-6 week wait to see a sessional GP. The nurses will try to link patients into other GPs in the community for ongoing care but patients that are Medicare-ineligible are more likely to continue attending the RHS due to limited options.

### Asylum Seekers Centre

The Asylum Seekers Centre (ASC) have established a health care program to look after clients who don't have Medicare or access to ASAS. It provides a range of comprehensive health services including:

- Primary care assessment and treatment
- Nursing care
- Health promotion
- Complementary therapies
- Assistance in meeting pharmaceutical costs
- Referrals for pro-bono dentistry, optometry, psychiatry and other specialist treatment (some of which is facilitated by St Vincent's Clinic)

- Advocacy and negotiation for fee-waivers
- Peri-natal support through the Australian Doula College

The health program is staffed by Registered Nurses, a volunteer doctor (half a day per week) and complementary therapy practitioners. In addition, the health staff are involved in policy development and training. As described earlier, ASC refer patients to St Vincent's clinics for investigations, some specialist consultation and pharmaceuticals.

### Other primary care service providers

The NSW RHS and ASC are limited in their capacity to service all asylum seekers' primary care needs due to restricted hours and the limitations of refugee health nurses. There are a number of other primary care providers who are equipped to care for refugees and asylum seekers that exist outside of the NSW refugee health service. Some of these may be willing to see clients without Medicare, for example the Haymarket clinic for the homeless. However, these services are generally not able to provide long-term care, so primary care for Medicare-ineligible asylum seekers is a major gap.

Local Health Districts in the Metropolitan areas providing refugee-specific programs include South Eastern Sydney, Illawarra Shoalhaven and Northern Sydney. Further consultation is required to scope these services.

## Mental health services

### Service for the Treatment and Rehabilitation of Torture and Trauma Survivors

The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) are the leading service provider for refugees and asylum seekers who have experienced torture and trauma. They have branches in Carramar, Auburn, Liverpool and Blacktown with outreach services in the Eastern suburbs. These have been established in relation to the areas where refugees and asylum seekers settle in NSW. The model of care involves a team approach with bicultural workers, social workers, counsellors, psychologists and psychiatrists.

To prioritise clients, an intake assessment is conducted. Services offered at STARTTS include:

- Individual and family counselling
- Group therapy programs
- Psychiatric services
- Physiotherapy and acupuncture to assist with chronic pain management
- Recreational activities for children and young people
- Skills building workshops
- Training and consultation for people working with refugees
- Advocacy and research
- Clinical consultation in detention centres and training of detention centre staff
- Bilingual and bicultural workers

### Asylum Seekers Centre

There is a small mental health service offered at the Asylum Seekers Centre run by a counsellor with appropriate knowledge and experience working with people from refugee backgrounds. They try to engage external mental health consultation where possible but because most of their clients are Medicare-ineligible, this proves to be very difficult.

### Transcultural Mental Health Centre

Transcultural Mental Health Centre is a state-wide service that focuses on the mental health needs of people from culturally and linguistically diverse (CALD) backgrounds. They provide:

- Assessment and consultation
- Prevention and early intervention
- Development of resources
- Education and training

### Other mental health services

A network of organisations that care for asylum seekers in Sydney have been trialling a model to improve referrals to mental health services, particularly the torture and trauma service, STARTTS. This mechanism was established after recognition that it was challenging to identify clients appropriate for the service. To assist, a mental health worker has been operating out of St Vincent de Paul Society and receives referrals from the various organisations. After conducting a mental health assessment, the client is referred to the appropriate service.

*There are likely to be many other mainstream mental health services that have cared for asylum seekers through counselling, psychological or psychiatric programs. Further consultation is required to scope these services.*

### Other refugee services

There are a number of paediatric services specialising in the provision of care to refugees. These include:

- Sydney Children's Hospital Randwick refugee child health clinic
- Westmead Children's hospital health assessments for refugee kids (HARK)
- Liverpool Hospital refugee paediatric clinic
- Refugee Youth Health clinic (Fairfield/Liverpool)

Further information is required to establish the extent of their service provision and whether asylum seeker children with bridging visas, with or without Medicare can access the service; or whether children in community detention arrangements are referred here for specialist assessment and treatment.

In addition to those services detailed above, a number of state-wide multicultural services also focus on refugees, although the extent of their involvement with the asylum seeker community has not yet been established through this scoping study. They include:

- Immigrant Women's Health Service
- Family planning NSW multicultural service
- Mater Private Sydney (maternity services)
- Kirketon Road Clinic
- Fairfield refugee nutrition program
- NSW Education Program on Female Genital Mutilation
- NSW Multicultural Health Communication Service
- Multicultural HIV/AIDS and Hepatitis C Service
- Education Centre Against Violence and the Drug
- Alcohol Multicultural Education Centre

## Non-Health Services

In Sydney, there are a large number of not-for-profit organisations providing a wide variety of services to asylum seekers in the community. Many organisations have formal or informal case worker programs. The range of services provided can vary and may fluctuate depending on available funding sources. The following table is an outline of these services. More information can be found by visiting the website or contacting the organisation directly.

### SYDNEY COMMUNITY-BASED ASYLUM SEEKER SUPPORT SERVICES

	CONTACT/LOCATION	REFERRAL TO HEALTH SERVICES	CASE WORK SUPPORT	FINANCIAL ASSISTANCE	ACCOMMODATION HOUSING	MATERIAL ASSISTANCE	LEGAL ADVICE	EMPLOYMENT ASSISTANCE	GENERAL INFORMATION & SUPPORT	SKILLS TRAINING EG. COMPUTER CLASSES	ADVOCACY, RESEARCH OR PUBLICATIONS	OTHER SERVICES
Asylum Seekers Centre	38 Nobbs Street Surry Hills 02 9361 5606 <a href="http://www.asylumseekerscentre.org.au">www.asylumseekerscentre.org.au</a>	✓	✓			✓		✓	✓	✓	✓	Recreational activities Referrals for financial, material aid, legal advice
Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) – Member of FASSTT	152 The Horsley Drive Carramar 02 9794 1900 <a href="mailto:startts@sswahs.nsw.gov.au">startts@sswahs.nsw.gov.au</a>	✓							✓	✓	✓	Recreational activities Complementary therapies
House of Welcome	140 Wattle Avenue Carramar 02 9727 9290 <a href="http://www.houseofwelcome.com.au/services/">http://www.houseofwelcome.com.au/services/</a>			✓	✓	✓		✓	✓	✓	✓	No interest loans Recreational activities



<b>OTHER SERVICES</b>	Recreational activities Community detention program			
<b>ADVOCACY, RESEARCH OR PUBLICATIONS</b>	✓			
<b>SKILLS TRAINING EG. COMPUTER CLASSES</b>	✓			
<b>GENERAL INFORMATION &amp; SUPPORT</b>	✓	✓	✓	
<b>EMPLOYMENT ASSISTANCE</b>				
<b>LEGAL ADVICE</b>				✓
<b>MATERIAL ASSISTANCE</b>	✓	✓		
<b>ACCOMMODATION HOUSING</b>	✓			
<b>FINANCIAL ASSISTANCE</b>	✓	✓	✓	
<b>CASE WORK SUPPORT</b>	✓		✓	✓
<b>REFERRAL TO HEALTH SERVICES</b>	✓		✓	
<b>CONTACT/LOCATION</b>	24 Roslyn St, Kings Cross 02 9356 3888 www.jrs.org.au	Five Dock NSW www.asylumseekersfoundation.org	2c West St Lewisham 02 9560 8666 www.vinnies.org.au/migrant-and-refugee-national?link=357	173-175 Phillip St Sydney 02 9114 1600 www.racs.org.au
	Jesuit Refugee Service	Bridge for Asylum Seekers Foundation	St Vincent de Paul Refugee Support Service	Refugee Advice and Casework Service

# Appendix E: Asylum seeker services Queensland

## Primary care services

### Refugee Health Queensland

Refugee Health services are located in:

- South Brisbane
- North Brisbane (Zillmere)
- Logan
- Toowoomba (Kobi House)
- Townsville
- Cairns

### South Brisbane clinic

There are two program streams within the South Brisbane clinic:

1. Health Assessments: Available for refugees within the first 6 months of settlement. This involves a comprehensive nursing assessment over 1 to 2 visits.
2. Extended Care: Available for refugees with complex needs and asylum seekers with or without Medicare.

The Extended Care program is supported by a full time nurse, full time administrative staff and five volunteer GPs. Services provided to asylum seekers through this program include:

- Nursing assessment
- Medical assessment
- Pathology testing, treatment and referrals
- Immunisations (funded by QLD Health)
- Referral to a community GP for ongoing care
- Long appointments
- Complex Care Management
- General GP services for asylum seekers
- Pathology, pharmaceuticals and radiology are provided free for asylum seekers without Medicare (ASAS or CAS)
- The service length is patient-driven so some patients will remain with the Extended Care program up to three years, to improve their health literacy. Other patients may not require ongoing consultation

In addition to the above services, staff are available to support General Practices on clinical and non-clinical matters.

## Mental health services

### Queensland Program of Assistance to Survivors of Torture and Trauma

In Queensland, the main mental health service provider for asylum seekers is QPASTT. QPASTT is a member of FASTT and they have services operating in:

- Brisbane (with outreach services to Logan and the Gold Coast)
- Cairns
- Townsville
- Rockhamptom
- Toowoomba

They offer a range of programs and services including:

- Individual counselling for children and adults
- Family counselling
- Youth programs
- Recreational activities
- Capacity building in the refugee health sector
- Training and education for general and mental health practitioners

- Policy development

Asylum seekers need to have CAS or ASAS to access QPASTT services. This relates to their available funding arrangements. Like the other torture and trauma services in Victoria and NSW, there is a need to prioritise clients based on an intake assessment due to high service demand. QPASTT have been actively involved in advocating for asylum seeker needs and assist in the development of new service models, based on their extensive knowledge of the sector.

### Queensland Transcultural Mental Health Centre

Queensland Transcultural Mental Health Centre (QTMHC) is a state-wide service that focuses on the mental health needs of people from culturally and linguistically diverse (CALD) backgrounds. They provide:

- Assessment and consultation
- Client advocacy
- Development of resources
- Education and training

QTMHC provide some direct clinical services to asylum seekers when a client requires mental health treatment but cannot access QPASTT or mainstream mental health services. They also provide some outreach consultation and work alongside community treating teams. They may be able to assist a GP or other referring service with finding a pathway of entry into community mental health services. Additionally, QTMHC are actively involved in advocacy and policy work to improve service access to asylum seekers and other CALD groups.

The following organisations have been identified through the consultation process as being providers of mental health care for some refugees and other CALD groups. Further information is required to determine their capacity to see asylum seekers with or without Medicare:

- Multicultural Centre for Mental Health and Well Being (Harmony Place)
- Centacare
- Queensland Multicultural Mental Health Coordinators
- Immigrant Women's Support Service
- Child and Youth Mental Health Services

### Other Health services

The following services are dedicated to meeting the needs of refugees or CALD groups. Further information is required to determine their capacity to assist asylum seekers with or without Medicare:

The Family Planning Queensland Multicultural Women's Health Education project

- Mater's Refugee Maternity Service
- Ethnic Communities Council of Queensland's Chronic Disease Programs
- Queensland Health have a Multicultural Services Directory which can be found online

### Non-Health Services

In Brisbane, there are several not-for-profit organisations providing a wide variety of services to asylum seekers in the community. The range of services provided can vary and may fluctuate depending on available funding sources. The following table is an outline of these services. More information can be found by visiting the website or contacting the organisation directly.

BRISBANE COMMUNITY-BASED ASYLUM SEEKER SUPPORT SERVICES

OTHER SERVICES			Recreational activities. Settlement for refugees Also facilitate ASAS/ CAS and community detention	*Currently do not have the financial support to provide most of these services
ADVOCACY, RESEARCH OR PUBLICATIONS	✓	✓		
SKILLS TRAINING EG. COMPUTER CLASSES				✓
GENERAL INFORMATION & SUPPORT	✓	✓	✓	✓
EMPLOYMENT ASSISTANCE		✓		✓
LEGAL ADVICE				
MATERIAL ASSISTANCE		✓	✓	✓
ACCOMMODATION HOUSING		✓	✓	✓
FINANCIAL ASSISTANCE			✓	✓
CASE WORK SUPPORT	✓		✓	✓
REFERRAL TO HEALTH SERVICES	✓	✓	✓	✓
CONTACT/LOCATION	28 Dibley St Woolloongabba 07 3391 6677 www.qpastt.org.au/ index.html	20 Dutton St Dutton park 07 3013 0100 http://romerocentre.org.au/	28 Dibley St Woolloongabba 07 3337 5400 www.mdainc.org.au/	12 Bonython Street Windsor 07 3357 9013
	Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT) - Member of FASSTT	Romero Centre	Multicultural Development Association	Refugee Claimants Support Centre*

<b>OTHER SERVICES</b>			
<b>ADVOCACY, RESEARCH OR PUBLICATIONS</b>			
<b>SKILLS TRAINING EG. COMPUTER CLASSES</b>	✓		
<b>GENERAL INFORMATION &amp; SUPPORT</b>	✓	✓	
<b>EMPLOYMENT ASSISTANCE</b>	✓		
<b>LEGAL ADVICE</b>			✓
<b>MATERIAL ASSISTANCE</b>			
<b>ACCOMMODATION HOUSING</b>		✓	
<b>FINANCIAL ASSISTANCE</b>			
<b>CASE WORK SUPPORT</b>			
<b>REFERRAL TO HEALTH SERVICES</b>			
<b>CONTACT/LOCATION</b>	14/478 Ipswich Rd Annerley 07 3421 1561	1098 Wynnum Road Murarrie 07 3890 8122 <a href="http://www.gatewaycg.org.au/">www.gatewaycg.org.au/</a>	170 Boundary Street West End 07 3846 3189 <a href="http://www.rails.org.au/">www.rails.org.au/</a>
	Spiritus Refugee and Migrant Services (ARMS)	Gateway Community Refugee Support	Refugee and Immigration Legal Service (RAILS)