

# Health Care of Asylum Seekers and Refugees - 2011

## Preamble

The Australian Medical Association affirms that those who are seeking, or who have been granted, asylum within Australia have the right to receive appropriate medical care without discrimination, regardless of citizenship, visa status, or ability to pay. Like all seeking health care, asylum seekers and refugees in Australia should be treated with compassion, respect, and dignity.

## Definitions

The United Nation's 1951 Convention Relating to the Status of Refugees (the Refugee Convention), and the 1967 amendment entitled the Protocol Relating to Refugees, to both of which Australia is a signatory, define refugees as persons who are:

- outside their country of nationality or their usual country of residence, and
- unable or unwilling to return or to seek the protection of that country due to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, and
- not war criminals or people who have committed serious non-political crimes.

Asylum seekers are people who apply to the Government of a country for recognition as a refugee.

**The AMA makes the following observations and recommendations in relation to the health care of asylum seekers and refugees:**

## Health and Welfare of Asylum Seekers and Refugees

1. In addition to suffering the same health problems as the general population, asylum seekers and refugees are at particular risk from a range of conditions including psychological disorders such as post-traumatic stress disorder, anxiety, depression, and the physical effects of persecution and torture. They may also often suffer the effects of poor dental hygiene, poor nutrition and diet, and infectious diseases such as tuberculosis, which may be more common in their countries of origin.
2. To determine their specific health needs, all asylum seekers and refugees should undergo comprehensive and timely health assessments in a culturally appropriate manner by suitably trained medical practitioners as part of a primary health care team. This assessment will be used to establish ongoing care.
3. All asylum seekers and refugees should have access to the same level of health care as all Australian citizens. In addition, it should be ensured that their special needs, including cultural, linguistic, and health-related, are addressed.
4. A national statutory body of clinical experts independent of governments should be established with the power to investigate and advise regarding the health and welfare of asylum seekers and refugees.

5. All asylum seekers and refugees, independent of their citizenship or visa status, should have universal access to basic health care, counseling and educational and training opportunities. Refugees and asylum seekers living in the community should also have access to Medicare and the Pharmaceutical Benefits Scheme (PBS), state welfare and employment support, and appropriate settlement services. Immigration policies that restrict the social and economic rights of disadvantaged groups of people, such as asylum seekers and refugees, can have adverse impacts on their health and wellbeing.

6. Health and welfare services for asylum seekers in detention and in the community should be adequately resourced and integrated at State and Federal level. This includes staff education, training, and support.

7. Refugees, and asylum seekers living in the community, should have continued access to culturally appropriate health care, including specialist care, to meet their ongoing health needs, including rehabilitation.

8. More research is needed into the health status and health care of asylum seekers and refugees, both within the community and in detention centres, to assist medical practitioners in the care of these groups, and the development of appropriate services.

9. More research is needed into the impact of immigration controls, such as the prolonged, indeterminate use of detention, on the health of asylum seekers, including those eventually determined to be refugees.

### **Medical Practitioners**

10. Medical practitioners should:

- act in the best interests of the patient;
- not authorise or approve any physical punishment, nor participate in any form of inhumane treatment, nor be called upon to do so by authorities; and
- provide medical treatment in a culturally and linguistically appropriate manner.

11. Medical practitioners should at all times insist that the rights of their patients be respected and not allow lower standards of care to be provided. In particular, the right to privacy and confidentiality must be protected.

12. Appropriate medical treatment teams should include members with the skills outlined above. Medical practitioners providing full assessment of asylum seekers and refugees should be suitably trained in:

- identifying victims of torture and assessment and management of related trauma;
- identification of suicide risk, screening for mental health conditions (including among children and adolescents) and monitoring and management of these conditions;
- responding to the medical, physical, emotional, and developmental needs of children and families; and
- recognising particular health-related conditions which may be more common in an asylum seeker's or refugee's home country than here in Australia (eg. tuberculosis).

13. Professional medical organisations should develop a set of ethical guidelines to support medical practitioners working with asylum seekers and refugees in whatever context.

### **Issues Specific to Asylum Seekers**

Asylum seekers are generally not afforded the same rights as refugees. They are often not given the same access to freedom of movement, to work, or to medical care. These restrictions can adversely affect health and wellbeing, particularly mental health. Issues specific to immigration detention centres are addressed below.

### **Immigration Detention Centres**

14. Prolonged, indeterminate detention of asylum seekers in immigration detention centres violates basic human rights and contributes adversely to health. The longer a person is in detention, the higher their risk of mental illness. Detention in immigration detention centres should be used only as a last resort, and for the shortest practicable time. Solutions to prolonged, indeterminate detention must be sought as a matter of urgency.

15. In order that asylum seekers do not spend a prolonged, indeterminate period of time in detention, the Government must set in law an absolute maximum duration that an asylum seeker can spend in detention. After such time, the asylum seeker should be allowed to live in the community while their visa application continues to be assessed. The determination of an absolute maximum time that asylum seekers can spend in detention must be undertaken with appropriate public consultation.

16. Where immigration detention centres continue to be used to detain asylum seekers, governments must provide basic humane standards of living conditions. They must strive to achieve world's best practice in all Australian detention centres, whether located within Australia or offshore. This includes accommodating the health, linguistic, cultural, social, educational, privacy, gender-specific and religious needs of asylum seekers.

17. Health and medical services in immigration detention centres should only be provided by organizations that have the full capacity to provide an appropriate range of health and medical care to all detainees as needed, and according to best practice standards in health care delivery (as would apply in the general community). Adherence to these standards should be guaranteed through a process of ongoing monitoring of detainees health by an independent statutory body of clinical experts with powers to acquire information and investigate conditions in centres as it determines.

18. The assessment and provision of medical care to asylum seekers in detention must be undertaken by medical practitioners.

19. Health screening should be undertaken by a medical practitioner or a nurse. Health screening for addictive, physical, and psychiatric problems, including potential suicide risk, should occur on admission to the centre. All significant medical findings should be referred immediately to a medical practitioner.

20. Medications should be administered by medical professionals or nurses and not detention centre staff, and provisions should be in place for the appropriate management of detainees' medications.

21. Detention center staff and management should ensure that the instructions provided by medical practitioners for the health and wellbeing of detainees are implemented.
22. Doctors providing services in immigration detention centres should be experienced medical professionals. Where junior doctors are contracted, they must have available to them appropriate medical professional support and advice, and their welfare should be ensured.
23. Continuity of medical care for detainees should be ensured as much as is reasonably possible and steps should be taken to avoid a high turnover of medical and other staff in services provided to detainees.
24. Reviews of detainees' health status must occur regularly.
25. The provision of health care is potentially constrained due to the physical and social environment of detention centres, particularly those located 'offshore'. Those in detention should have timely access to good quality ongoing health care, including emergency and specialist services, to the same standard as is available to Australian citizens. Those who require assessment or treatment that cannot be undertaken within the detention centre environment should be transferred to an appropriate centre in a timely manner.
26. Those in detention should have access to appropriate specialist services including obstetric and gynaecological services, antenatal and postnatal care, paediatric services, mental health, rehabilitation, allied health services, and dental services.
27. Continuity of care needs to be maintained for refugees and asylum seekers released into the community. They should be fully informed about the Medicare and PBS schemes and how to access the full range of health care and medical options available in the community. Provision must also be made for ongoing social support services in the community when an asylum seeker is released.
28. Individuals who are released into the community must have timely access to their medical records from their time in detention. Those who are deported should receive a copy of their medical record from their time in detention to take with them.
29. Any measure to reintroduce Temporary Protection Visas (TPVs) must be opposed. These visas impose undue stress and anxiety on individuals because they cannot apply for permanent visas and are unable to travel in and out of Australia, or access family reunion schemes. TPVs undermine the ability to successfully integrate into the community.
30. All asylum seekers and refugees should be afforded access to Government support services, including entitlement to family reunion and settlement services.

### Children

31. Children are particularly vulnerable and the detention environment places enormous stress on them. Children often witness behavioural and psychological distress in adults, including their parents, violence and self-harm, and experience separation from family members.
32. Children appear to be at particular risk of sexual violence.

33. An unaccompanied child should never be placed in detention.

34. An accompanied child should be kept in detention for the shortest possible time, but no more than one month. By the end of one month, a suitable placement for the child with at least one adult family member must be identified.

35. Children and their families should never be placed among the general detention centre community, but should reside in a separate living area.

#### Hunger Strikers

36. The AMA believes that the detention centre environment should never become so intolerable that asylum seekers would consider going on a hunger strike as a means of protesting about their living conditions. Similarly, visa-processing procedures should be expedited to avoid self-harm due to frustration.

37. Where an individual voluntarily refuses nourishment and is considered by a medical practitioner to be capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, the practitioner should be free to refuse to co-operate in artificial feeding. The decision as to the capacity of the individual to form such a judgment should be confirmed by at least one other independent medical practitioner. The practitioners must explain to the individual the consequences of refusal of nourishment.

38. Doctors should become involved with the hunger strikers before, or immediately upon commencement, of a hunger strike in order to continually assess the hunger striker's physical and mental health, counsel the hunger striker regarding the adverse health effects associated with going on a hunger strike, and discuss with the hunger striker his/her wishes regarding artificial nutrition/hydration should he/she lose decision-making capacity. Health staff should have free and unfettered access to hunger strikers.

39. In accordance with the World Medical Association Declaration on Hunger Strikers (Declaration of Malta), if the hunger striker loses decision-making capacity, the doctor must be free to make treatment decisions that he/she considers to be in the best interests of that particular individual.

40. It is recognised that an individual who takes part in a group hunger strike may feel pressured by the other participants to continue the strike, even if he/she does not want to continue. A hunger striker must be allowed to withdraw from the hunger strike at any time, for any reason.

#### **See also:**

AMA Code of Ethics 2004 – Editorially Revised 2006.

World Medical Association Declaration on Hunger Strikers (Declaration of Malta), as editorially revised at the 44th World Medical Assembly Marbella, Spain, September 1992.

World Medical Association Declaration of Tokyo, Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment as adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975. and editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005 and the 173<sup>rd</sup> Council Session, Divonne-les-Bains, France, May 2006.

## BIBLIOGRAPHY

Australian Human Rights Commission. *Immigration Detention Report* Commonwealth of Australia 2008.

Australian Human Rights Commission *Immigration Detention on Christmas Island* Commonwealth of Australia. 2010.

Christopher Bowen. Minister for Immigration and Citizenship. *New Directions in Detention - Restoring Integrity to Australia's Immigration System* Speech. Australian National University, Canberra, Tuesday 29 July 2008.

Correa-Velez I, Johnston V et. al. Community-based asylum seekers' use of primary health care services in Melbourne. *MJA* 2008; 188: 344-348.

Department of Immigration and Citizenship. *Detention Health Framework*. Commonwealth of Australia 2007.

Green, PJ and Eager K. The health of people in Australian immigration detention centres. *MJA* 2010; 192: 65-70.

Human Rights and Equal Opportunity Commission *A last resort? The national inquiry into children in immigration detention* Sydney. April 2004.

Momartin S, Steel Z, et. al. A comparison of the mental health of refugees with temporary versus permanent protection visas. *MJA* 2006; 185:357-361

Palmer MJ. *Inquiry into the circumstances of the immigration detention of Cornelia Rau* Report. Canberra Commonwealth of Australia. July 2005.

Phillips CB. Immigration detention and health. *MJA* 2009; Rapid Online Publication 14 December.

United Nations. *Conventions relating to the Status of Refugees*, as adopted on 28 July 1951 under General Assembly resolution 429 (V) of 14 December 1950.

United Nations. *Protocols relating to the status of Refugees*, as taken note of by the General Assembly in resolution 2198 (XXI) of 16 December 1966.

Reproduction and distribution of AMA position statements is permitted provided the AMA is acknowledged and that the position statement is faithfully reproduced noting the year at the top of the document.