Australian Immigration Detention:
How Should Clinicians Respond?

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…the refugee is a problem residing at the very centre of our democratic consciences and our democratic institutions. The refugee tells us, face to face, from a distance, at the edges of our shores and in our camps, that we are not democratic: that we are not who we think we are or who we pride ourselves to be.

Matthew Holt
Biopolitics and the “Problem of the Refugee”
2003

It’s a well-worn solution to an intractable human problem involving a large group of inconvenient people – ship them off somewhere, put a wall (whether of ocean, stone or steel) around them, and try to forget about the whole thing. You could argue that our country was founded as a result of this approach. You could also argue that we learned our lesson too well, because it’s an approach we are still using when it comes to vulnerable people who have undertaken hazardous ocean journeys – and the outcomes are no more humane than they were in the 18th and 19th centuries.

Meg Keneally
Australia was Born out of a Gulag. Not Much has Changed
2017
Abstract

Australian immigration detention violates human rights and international law. Clinicians and professional healthcare bodies have been central to its operation, both providing healthcare within detention centres and protesting its consequences. Since its introduction over 25 years ago and despite ongoing protest the government has continued to implement increasingly opaque and punitive policy. How should clinicians respond? This thesis sets out to challenge over 20 years of thinking on this topic, calling for a shift in how clinicians and professional bodies engage with Australian immigration detention. I argue that current responses to the health and healthcare needs of those detained are inadequate. I reject a boycott but call for such action to be seen within a broader strategy aimed at bringing about social and political change. I propose a theoretical base to inform such a stance, by appealing to social movement theory and other theories of social change. I demonstrate how such theory can be applied to inform systemic, social and political change, and I argue that clinicians and professional bodies should embrace this approach which includes employing forms of political action such as protest, disruption and civil disobedience.
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To those who have suffered at the hand of Australia’s policies, thank you for your stoicism. I hope this influences future policy in some small way so others do not have to suffer needlessly.

To mum and dad, thank you for giving me the opportunities you did and supporting me for many years. I wouldn’t have got here without you. And thank you to Mani, although you only had to deal with me for half of this thesis, thank you for your patience and perseverance, you have been an amazing support. I love you lots.
Statement of Originality

This is to certify that the content of this thesis is my own work. This thesis has not been submitted to any other university or institution as a part or whole requirement for any higher degree.

I am the principal researcher in all work contained in this thesis. I had final editorial authority over all published articles included within it. All published works included as part of the thesis are included in the list of publications and presentations.

Ryan Essex

Signature  Date: 19/03/2019
Contribution Statement and Authorisation

The role played by co-authors included in the portfolio of published work was as follows:

Professor David Isaacs provided intellectual input into the review of the article, “The Ethics of Discharging Asylum Seekers to Harm: An Example from Australia”. Poonkulali Govintharajah provided intellectual input into the review of the article “The Health of Children and Families in Australian Alternate Places of Immigration Detention”. I retained final editorial authority on all published articles included in this thesis.

While included in my portfolio of published work, I was only signatory to the “Open letter on the Border Force Act”. I played no role in drafting, reviewing or editing its content. It was included here because of its personal relevance and relevance to this thesis.

The undersigned certify that they consent to their published work being included in the thesis and they have each accepted the contribution statement above. Each also acknowledges that if I am awarded a higher degree for the thesis, it will be included in the collection of the University library, and that copies may be made by the University for use and distribution by the library according to the University’s rules and policies.

Professor David Isaacs

Signature …………………………… Date…………………………

Poonkulali Govintharajah

Signature …………………………… Date…………………………
As supervisor for the candidature upon which this thesis is based, I can confirm that the authorship attribution statements above are correct.

Associate Professor Christopher Jordens

Signature… Date 25.3.2019
Supervisors Certification

I, Associate Professor Christopher Jordens, certify that the PhD thesis entitled ‘Australian Immigration Detention: How Should Clinicians Respond?’ by Ryan Essex is in a suitable form for examination.

Associate Professor Christopher Jordens

Signature……….. Date 25.3.2019
List of Publications and Presentations

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Common Abbreviations

ACHSSW
Australian Council of Heads of Schools of Social Work
AHRC
Australian Human Rights Commission
AMA
Australian Medical Association
APOD
Alternative Place of Detention
APS
Australian Psychological Society
DIAC
Department of Immigration and Citizenship
DIBP
Department of Immigration and Border Protection
DIMA
Department of Immigration and Multicultural Affairs
IDC
Immigration Detention Centre
IHAG
Immigration Health and Advisory Group
IHMS
International Health and Medical Services
IRH
Immigration Residential Housing
ITA
Immigration Transit Accommodation
OPCAT
Optional Protocol to the Convention against Torture
RACP
Royal Australian College of Physicians
RANZCP
Royal Australian and New Zealand College of Physicians
SCT
Social categorisation theory
SIT
Social identity theory
UN
United Nations
UNHCR
United Nations High Commissioner for Refugees
Definitions

**Australian immigration detention**: Since immigration detention was introduced in 1992, the Australian government has maintained four different types of centre: Alternative places of Detention (APODs), Immigration Transit Accommodation (ITA), Immigration Residential Housing (IRH) and Immigration Detention Centres (IDCs). APODs, ITA and IRH were used to detain children (Department of Immigration and Border Protection [DIBP], 2016) and those considered vulnerable, usually due to illness. They feature a number of superficial improvements to IDCs and were described in the Australian Human Rights Commission Forgotten Children Report (AHRC, 2014) as follows:

The facility [Sydney Detention Centre] contains four duplex houses, each of which has three bedrooms, two bathrooms, shared kitchen, living and dining areas and a garage area that can be used for visits. The houses face a common area which contains grassy space and a small garden. There is a children’s playground, a basketball half-court and a small undercover recreation area. It is next to Villawood Detention Centre. The facilities are highly preferable to other detention facilities in Australia. However, Sydney Detention Centre is still a locked detention facility where people are not free to come and go (p. 174).

The Inverbrackie Detention Centre in Adelaide comprises 75 houses … Unless the houses are occupied by a large family they are usually shared with other families. These houses provide a friendlier environment for children. Families have some privacy and while they may share a kitchen space, they are able to cook and eat together. Nevertheless, there are reminders that Inverbrackie and Sydney are detention centres. There are four head counts per day and people are not free to leave the fenced communities (p. 130).

All adults and children who are detained offshore are accommodated in IDCs. All evidence indicates that remote centres and particularly offshore centres are far worse in terms of facilities and environment than those found in closer proximity to cities and urban centres.

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1 Although referred to as Sydney IRH by the Australian government, the Forgotten Children Report refers to this centre as Sydney Detention Centre.
Refugees, asylum seekers and detainees: The terms refugee and asylum seeker should be interpreted in line with their international legal definitions (United Nations [UN] General Assembly, 1951, 1967). The term ‘detainee’ is used to refer to anyone who is detained. This may be anyone without a valid Australian visa, not just refugees and asylum seekers. An asylum seeker is someone who has fled their country and applied for protection as a refugee (AHRC, 2015). According to the UN Convention Relating to the Status of Refugees (1951, art. 1), a refugee is any person who:

…owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.

Clinicians and Professional Healthcare Bodies: The term ‘clinicians’ is used here to refer to health care professionals who were formerly or are currently employed by IHMS. It is also used to refer to healthcare professionals more generally. A complete list of clinicians who are now legally allowed to discuss their current and previous employment was included in the amendments made to the Border Force Act (2015) in September 2016 (Doherty, 2016b). This list includes Doctors, Nurses, Psychologists and Counsellors among a number of other healthcare professionals. The peak bodies who represent the above clinicians are referred to as professional healthcare bodies. The list of bodies discussed here is not exhaustive and the discussion has been limited to bodies with large memberships that have made notable contributions to discussions surrounding Australia’s policies, or that have been notably absent from them.

The Australian Immigration Department: The Australian Immigration Department has taken a number of forms, both historically and throughout this thesis. This department will be referred to as the Department of Immigration and Citizenship (DIAC), Department of Immigration and Border Protection (DIBP), Department of Immigration and Multicultural Affairs (DIMA) and as the Immigration Department. Most recently this department has been renamed the Department of Home Affairs. While each has differed slightly in its scope, this
department has had almost sole responsibility for the day to day operation of Australia’s immigration detention centres and for the implementation of government policy on immigration.
Preface

I began working in Australian immigration detention with International Health and Medical Services (IHMS) in March 2011. I was initially placed at Inverbrackie Alternate Place of Detention (APOD) in the Adelaide Hills. Inverbrackie was opened by Julia Gillard, the then Prime Minister and leader of the Labor Party. There was much community uproar because the centre was located in an electorate that had been safely held by the conservative Liberal Party for over 20 years. The centre consisted of a mix of refurbished army housing, converted administrative buildings that were formerly converted shipping containers, and a small green pool fence surrounding the centre. The medical centre was on site. There was day care and activities for infants. School age children were taken to school each morning and the facilities allowed some autonomy. The environment was nevertheless far from perfect and many detainees still waited prolonged periods of time before they were granted their visa. The ability to take charge of certain aspects of day to day life, such as cooking, cleaning and entertaining, offered some relief from the monotony and uncertainty associated with being detained. It was a strange place particularly given the reputation of Australia’s immigration detention facilities. I visited people’s houses, attended birthday parties and even smuggled DVDs into the centre with a guard. (The recipient was a musician and insisted on learning English through an Eagles live DVD). Inverbrackie provided a relatively easy start for what was to be my four years working in immigration detention. It also did a good job of masking the true intent of this system.

My next placement was in Curtin Immigration Detention Centre. A week before I arrived, there was a mass “escape”. Forty men had found a section of un-electrified fence and simply pushed it over. There was no genuine intent to escape: they knew they would not get far because the centre was remote and the environment was treacherous. They turned back shortly after. Curtin was located in an air force base 40 km from the small Kimberley town of Derby. Red dirt found its way into everything and most days the temperature neared 40 degrees. On my arrival the immigration department had referred all 40 men for mental health assessments for what was seemingly completely rational behaviour given the circumstances. This was not the first or last time that completely normal behaviour was seen to warrant a mental health assessment.
In my first week there was a mass hunger strike which escalated over a period of days, finishing in mass self-harm. The medical team triaged and treated over 20 men in what took the best part of an afternoon. This tension was never far from the surface. One soon became well versed with the “Psychological Support Program”. This was a euphemism for suicide watch, a term which was rarely used in Inverbrackie. Staff were always monitoring several people, some constantly for weeks and even months at a time. Over time, things became increasingly despairing. The centre was at double its capacity: gyms had been converted to dorms and there was almost no common space left. This growing population and the fact that everyone’s case had seemed to stagnate most had now been waiting for two years, with little news on their claim for asylum. This was immensely difficult to deal with as a Counsellor. I was little more than a witness to suffering.

It was not until my final months at Curtin that the immigration department started moving asylum seekers (whom it called ‘detainees’) into the community. This was due more to the fact the centre had exceeded its capacity, than to advocacy on the part of the mental health team. Almost everyone I worked with had been moved to the community. In the months leading up to this, the mental health team had been writing to the department, outlining our concerns for each person and recommending “less restrictive environments”. Such vague language was often used to soften what may have been construed as “advocacy”. How people were selected for community detention, however, still appeared completely arbitrary, and this only heightened the already palpable sense of injustice. Nevertheless, occasionally you could still get things done, not through therapeutic work so much as by cultivating a rapport with the people who could make a tangible difference—that is, people who worked for the department of immigration. This was confirmed in my final week. I had been working with a client who had been detained for over two years and had not heard anything about his case. He was stateless; he kept a low profile while in detention, and he was very likely to be granted refugee status at some point. I had written to the immigration department outlining my concerns multiple times. In my final days and in my frustration I approached a senior department of immigration employee. I caught him face to face and re-iterated what I had already written multiple times. He sent my concerns to Canberra, my client was notified he would be moved to the community the next day.

Villawood Immigration Detention Centre already had a notorious reputation before I arrived. Riots only nine months earlier meant IHMS was relegated to a few small cells and interview
rooms that were converted into a “medical centre” to serve the needs of anywhere up to 400 people. Initially, the most striking thing about Villawood was how ad hoc it appeared. It originally opened as migrant housing in the 1940s and was converted to a detention centre in the 1970s. A range of different accommodation and security measures had been thrown together to meet whatever need the government had at the time. It stood in contrast to Curtin’s purpose-built, four-metre-high, double electrified fences and sterile shipping container infrastructure. The design flaws throughout Villawood allowed people to escape frequently, climb on the roof and protest and its flammability (which had been tested nine months earlier), were testament to its inadequacy to fulfil even the immigration department’s needs let alone the needs of those detained.

Villawood had a different population from most other centres. It housed people who had overstayed their visa, those who had had their visa cancelled on character grounds (in 2012 this was usually people who had served a custodial sentence for longer than 12 months) and those who had arrived in Australia seeking asylum, both by plane and boat. It was also used to accommodate people who had in some way been disruptive while detained elsewhere, who were deemed high security or who were being deported. This meant there were a lot of people in Villawood who had nothing left to lose.

If I had any doubts about the cruelty and stupidity of this system, these were put to rest during my time in Villawood. While I could count some small victories in Curtin, having had a number of people moved to the community, this was not the case at Villawood. It was the last stop for many. If you stood any chance of being released to the community, you would often be waiting for years. Small requests were often denied and even though we had allies in the department, they too had little power to effect change. While the medical team was often involved in all major meetings across the centre, your position became obvious after only attending one or two. Security and administrative concerns would always trump health and welfare. Medical opinion carried weight only when it suited the department’s objectives or supported the day to day operation of the centre.

The day I arrived at Villawood there was a death in custody. There were to be three more before I left. Ahmad Ali Jafari was one of them. I met Ahmed shortly after arriving in Curtin. I had worked with him closely for over 6 months. He was a quiet, pleasant and respectful man. He remained hopeful about being granted refugee status in Australian but became increasingly
despairing as time went on. I am not sure whether he was placed in the community or notified of a placement in the community before I left Curtin. In either case I left knowing he was likely to have his claim for asylum considered while waiting in the community. It was unexpected that he returned to Villawood. The immigration department had detained him as they believed he had criminal convictions overseas. He denied this, and from what I knew of him, it seemed unlikely. He got the documents that cleared him a few months later and these were provided to the department. I and a number of other staff advocated for his release for months. There was no good reason for him to remain in detention. He was detained for almost 12 months before he died on 20 June 2013, unnecessarily and unjustly detained in Villawood. He was 26 years old.

This thesis will never remedy any of these wrongs. Nevertheless, I hope it goes some way to challenging our current understanding and influencing how clinicians and professional healthcare bodies act in response to Australian immigration detention. I also hope it translates existing outrage into more effective action and provides a foundation for more sophisticated political engagement with these issues. I had initially approached this as an empirical project, simply because I felt there were stories that needed to be told. After the Border Force Act (2015) came into effect, however, it became unlawful for clinicians who worked in immigration detention to disclose what they had thereby come to know. I was troubled by a question that I had seemingly been asking myself for years: What should we do? In many respects things have come full circle, many of the themes throughout this thesis resemble many of the issues I struggled with years ago while working in detention: the futility in delivering care, the lack of guidance and external support, the limitations of traditional clinical work within a system that actively undermines health and healthcare.

Finally and despite all of this, it is often not the despair and hopelessness that I remember. Day to day there were human moments and room to bend the arbitrary rules, engaging in small acts of resistance. There were many who stood stoic and defiant in the face of injustice and, sadly, there will be many who continue to do so. To this day I feel privileged to have heard their stories and be welcomed into what was their temporary home.
Portrait of Ahmad Ali Jafari’, Safdar Ahmed, pencil on paper, 21x29cm
Overview

Introduction

In Australia, immigration detention has been one of the most contentious contemporary political issues for over 25 years. Since its introduction, tens of thousands of people seeking protection have been detained for protracted and occasionally indefinite periods of time. The harm created and perpetuated by these policies is deliberate, with bipartisan political support for an approach based on deterrence. In practice this means tens of thousands of men, women and children have been detained in squalid conditions and exposed to violence, riots, physical and sexual assaults, self-harm and suicidal behaviour as a means to deter others (Australian Parliamentary Select Committee, 2015). This has resulted in condemnation, both domestically and internationally, and led many to describe Australia’s approach toward refugees and asylum seekers as state-sanctioned child abuse (Owler, 2016), cruel and degrading (Mendez, 2015), a crime against humanity (Doherty, 2017b) and likened to torture (Berger, 2016; Boochani, 2016; Doherty & Hurst, 2015; Essex, 2016d; Isaacs, 2015a; Perera & Pugliese, 2015; Sanggaran & Zion, 2016).

Healthcare has been provided within Australian immigration detention since its introduction. The near futility of doing so has been well documented and, despite persistent criticism for over two decades, conditions have only deteriorated (Dudley, 2016; Mares, Newman, Dudley, & Gale, 2002). Outside of detention, clinicians and professional healthcare bodies have advocated for change, with the healthcare community forming a small part of a larger chorus of criticism that has involved lawyers, artists, academics and concerned citizens (Berger, 2016). The government, however, has been belligerent in the face of criticism, not only dismissing or ignoring the advice of clinicians and professional bodies, but attacking critics more generally (Borrello & Glenday, 2015).

How should clinicians respond to Australian immigration detention? In this thesis I will argue while the need for systemic, social and political reform has been well recognised, present approaches have evidently failed to achieve such change. This thesis will argue for a new approach that broadens the theoretical foundation on which future action should be based. More
practically, I reject a boycott as both unethical and infeasible and instead call for clinicians and professional bodies to see themselves in a broader context, as having central roles in bringing about social and political change, including taking contentious and adversarial forms of political action.

This Thesis in Context

Throughout the time I worked within immigration detention centres and the years this thesis took to write (2011-2019) the Australian government has shifted its approach toward asylum seekers and refugees. While many of these changes will be discussed below—including how recent legislation impacted on this thesis—with time, many parts of this thesis will be better understood in context.

When I started working in immigration detention in 2011, the practice of offshore processing had been abandoned. There was, however, an increasing number of boat arrivals and subsequent political hysteria. In 2012, offshore processing was re-introduced, and the government declared that anybody who arrived by boat would not be resettled in Australia in 2013. While I was writing this thesis, tens of thousands of men, women and children have suffered in offshore and onshore detention centres and the Australian government has become increasingly belligerent in the face of criticism.

Now, toward the end of 2018, the government has opened the gates of detention centres on Nauru and Manus Island. Few children remain detained onshore and offshore. Furthermore, the Australian government continues to pursue resettlement deals with third countries for those who remain on Manus Island and Nauru. Thus, it is likely that in the coming months and years, if the question were asked again, ‘How clinicians and professional healthcare bodies should respond to Australian immigration detention?’ the answer could be very different. Even if the government drastically changed its policy, however, this thesis would still have broader relevance and contain insights for future action. As I will discuss in later chapters, I draw on theories that recognise that social and political change more often than not occurs over the longer term. In addition, the question of how clinicians and professional healthcare bodies should respond to major human rights abuses will be, unfortunately, an enduring one.
At a time when reason and evidence are under increasing threat, where migration is increasingly demonised by governments across the globe and where health and healthcare are increasingly commodified, many of the ideas here sit amongst a number of emerging literatures that recognise the limitations of traditional clinical or medical ethics when it comes to issues that implicate politics and power. This thesis also sits alongside established literatures that recognise the importance of collective action in securing rights and challenging harmful policy; and that addressing major human rights violations often calls for more than condemnation.

Format of Thesis

This thesis has two parts. The first is presented as a traditional thesis, which answers the question posed by the title: How should clinicians respond to Australian immigration detention? The second part of this thesis is a portfolio of articles that were published during my candidature. All articles focus on health and healthcare in Australian immigration detention. While they share many similar themes to the first part of this thesis and while there may be some overlap in this sense, the papers address discrete issues that I have grappled with in order to arrive at an over-arching argument that is presented in this thesis. My portfolio of publications includes an “Open Letter on the Border Force Act” (The Guardian Australia, 2015). While I was only a signatory to this letter, it is included here because of its personal relevance and because of its significance for this thesis, which is described in Chapter 1.

Scope and Method of Thesis

This thesis focuses on onshore and offshore immigration detention but will also discuss Australia’s extra-territorial border controls and the issues facing the Asia-Pacific Region, as any reform of Australia’s policies is likely to have regional repercussions. While the treatment of refugees and asylum seekers in the Australian community also raises concerns, this thesis will also limit discussions to held detention\(^2\). That is, immigration detention centres (IDCs), immigration residential housing (IRH), immigration transit accommodation (ITA) and

\(^2\) Held detention refers to more traditional forms of detention, that is, institutional settings where movement is restricted and most elements of day to day life are dictated by the immigration department and security contractors. This is opposed to community detention, where people live in the community with conditions and restrictions placed on them (i.e., being unable to work) but without physical supervision.
alternate places of detention (APODs). While the issues facing refugees and asylum seekers are global and ongoing discussions about global justice remain important, this thesis does not consider a global response.

Under Australian law anyone without a valid visa can be detained. This thesis however focuses on refugees and asylum seekers and particularly those who attempt to travel to Australia by boat. There are a number of reasons for this. Australia has agreed to be bound by a number of international legal and human rights instruments which create clear obligations in relation to the treatment of refugees and asylum seekers. The most punitive policies, such as offshore processing, target those who travel by boat. Additionally, boat arrivals, despite their relatively small numbers3, have been one of the most controversial contemporary political issues in Australia.

All statistics and policy will be current up to the end of 2017, although I will occasionally refer to more recent developments. Whilst this thesis focuses on more recent policy, historical events and key policy developments will also be discussed as required.

My method of research throughout this thesis, and particularly in Chapters 1, 3 and 6, is best described as a “critical interpretive review”. This type of review aims to “develop new knowledge based on capturing and critiquing the key ideas from existing literature” (McDougall, 2015, p. 91) and is common in bioethics research. Such a review, while thorough, is not systemic in the sense of attempting to assemble every relevant piece of research. This is because research questions in bioethics differ fundamentally from those in other health and medical disciplines. As discussed by McDougall (2015, p. 91) research questions in bioethics “tend to focus on ethical justifiability and deal in conceptual analyses and arguments” and as a result it is often unnecessary or inappropriate to include all relevant literature.

Thesis Outline

In Chapter 1 I outline Australia’s policy of mandatory immigration detention, providing a brief historical and political context while highlighting policy that is particularly relevant for future

3 Relative to the rest of the world and relative to Australia’s migration program more generally, discussed further in Chapter 1.
action. I first consider the global and regional context in which Australia’s policies have developed, focusing on Australia’s role in the Asia-Pacific region. I describe Australia’s investment and influence in the region, and the impact this has had on promoting tighter border controls across the Asia-Pacific region. I then outline a brief history of immigration detention, focusing on the contemporary politics of these policies, including the government’s consolidation of power, the nature of “administrative detention”, the bipartisan support it receives, and the government’s unwillingness to consider alternative policies. I also describe the Australian Border Force Act (2015), which for a period of time increased the secrecy surrounding Australian immigration detention, and which had a direct impact on this research. I describe the devastating impact of these policies on those detained, with a focus on health and human rights. In the final section of Chapter 1 I move beyond description to explain why Australia’s approach is one of the harshest in the western world, and I identify historical, social and political factors which have led to present day policies.

In Chapter 2 I outline the standards to which Australia should be held in relation to its policies toward refugees and asylum seekers. Human rights provide a powerful platform on which to base objectives, not only because they are internationally accepted norms, but also because Australia is signatory to all major human rights instruments. Importantly these standards shift the focus of action from health and healthcare to rights and justice. They are based on the recognition that health is dependent on human rights first being upheld, and that human rights cannot be upheld within Australian immigration detention. I argue that future action should therefore focus on systemic, social and political change consistent with human rights and international law. I will set out ten specific standards and ground these in human rights and international law.

Chapter 3 will evaluate present responses to tackling the problems associated with health and healthcare in Australian immigration detention centres. I will first outline the contractual and administrative arrangements for healthcare within immigration detention. I then outline the problems that arise in the delivery of healthcare, focusing on the testimony of clinicians (including some reflections on my own experience) and detained refugee and asylum seekers. I will then discuss the ethics literature, focusing on how the literature has framed the issues related to health and healthcare as ethical problems and the guidance that comes from this. I will then discuss what professional bodies have said about health and healthcare in Australian immigration detention, focusing on their position statements. I will discuss the political actions
taken by clinicians and professional bodies outside of detention. Finally, I will evaluate the current and previous responses from clinicians and their professional organisations. I will argue that despite the recognition that systemic, social and political reform is needed, the literature and position statements from professional bodies are inadequate to inform such change. I will advance two related but distinct arguments that outline why this is the case. First, present responses individualise health, healthcare and the resolution of dilemmas within immigration detention. Second, despite over two decades of protest, current concepts and guidance offer little strategy or direction to pursue the systemic, social and political change proposed in Chapter 2.

The problems discussed throughout Chapter 3 raise the question of whether clinicians should work in immigration detention at all. Chapter 4 therefore deals with the question of a boycott. I will draw upon Selomgo’s (2013) criteria related to medical boycotts to begin to outline key questions as they relate to Australia’s policies. While the costs and benefits of engaging with Australian immigration detention can be assessed, the impact of a possible boycott can only be discussed hypothetically. This includes the steps the government could take in response to such action, the compromises that might need to be made and, most importantly, the harm that could be done to detainees. While a boycott is appealing when weighing the costs and benefits of current engagement, the potential harm it could do provides reason to be, at the very least, cautious. I conclude that under current circumstance a boycott cannot be ethically justified. Regardless of this—and even if this line of argument is not accepted—a boycott appears unlikely into the foreseeable future because there is a lack of consensus in the healthcare professions. Future action should plan accordingly.

Chapter 5 builds on the shortcomings identified in Chapter 3. I will call for two shifts. The first is a greater politicisation of health and healthcare in Australian immigration detention. This means a greater acknowledgement of the trade-offs that come with working within the system, but more importantly a greater focus on justice and rights rather than routine clinical issues. The second shift is closely related to the first, and entails expanding the roles that clinicians and professional bodies have outside of detention. I argue that this should go beyond familiar action, such as research and advocacy, or what Raphael (2009, p. 145) calls “professionally-oriented approaches,” and be driven instead by a “movement-based approach”. While professionally-oriented approaches typically attempt to persuade those in power to change, movement-based approaches pursue change by more adversarial methods, and from “below”
(i.e. through grassroots action). I will discuss the concepts of the humanitarian border, Subašić et al.’s (2008) model of political solidarity and more broadly, the literatures of public health ethics and social movement theory, because each has the potential to invigorate and broaden the repertoire of clinicians’ responses to immigration detention. I will then argue that while these theories address many of the shortcomings found in the existing literature, the concepts and guidance critiqued in Chapter 3 should not be dismissed completely, and instead should be placed within a broader set of conceptual tools and a wider repertoire of options for practical action.

Chapter 6 will explore how Subašić et al.’s (2008) model of political solidarity and social movement theory can be applied, with a focus on how they should be utilised in planning future action. I argue that Subašić et al.’s (2008) model significantly improves on existing literature dealing with social change by accounting for the dynamic relationship between those in power, the general population and those detained. It remains limited in its scope, however, and says little about the practicalities of building support, particularly given the political and social circumstances in Australia. Social movement theory fills a number of these gaps. Utilising Tarrow’s (2011) framework of contentious politics I will first outline some key features of social movements and, more broadly, contentious politics. I will then apply social movement theory to a number of episodes of contention related to Australian immigration detention and discuss what lessons can be generalised from this. Importantly and most broadly, social movement theory allows us to better understand responses to complex social problems and social change. It allows for an exploration of issues across time and place, identifying commonalities, differences, successes and failures. It gives insight into why movements were successful or unsuccessful in achieving their goals and (most importantly for the research question posed here) it provides a foundation on which future action can be planned. I will also discuss some important caveats concerning this literature, particularly that it does not offer a “road map” to success. The dynamic and relational nature of social change makes planning beyond the immediate to medium term difficult. The context of social change also needs to be given careful consideration. Finally, while social movement theory has substantial explanatory value it says little about the type of action that is justified or why clinicians should respond. I will discuss this and argue that all non-violent action including disruption of the detention system and civil disobedience are justified. I will then outline why clinicians should act, and in particular why they should consider contentious and adversarial action part of their repertoire in any future response.
Chapter 7 will provide a summary of this thesis. I will then discuss some limitations and potential objections. In response to the latter, I offer further clarification on what I see to be some of the more contentious elements of each chapter. I will justify why I have chosen to focus on clinicians’ roles outside of detention, rather than the roles of those working within detention. Informed by the standards outlined in Chapter 2 and the ideas introduced throughout this thesis I will then discuss directions for future research and action, focusing on six areas: what should be done in relation to a boycott; future directions for those working in detention; future directions in taking social and political action; collaboration and cooperation; how clinicians should contribute to the reform of Australia’s regional approach, and how clinicians can promote and facilitate international pressure on the Australian government.
Chapter 1  Australian Immigration Detention and its Consequences

1.1  Overview

Chapter 1 outlines Australia’s policy of mandatory immigration detention, providing a brief historical and political context and discussing its impact on human rights and the health and wellbeing of those detained. I will first describe the global and regional context in which Australia’s policies have developed, focusing on the impact these polices have had on promoting tighter border controls across the Asia-Pacific region. I will then describe the introduction and evolution of Australian immigration detention, including the contemporary politics that underpin these policies. I discuss immigration detention’s status as administrative detention and the bipartisan political support it has received. Closely related to this, but deserving of special attention, are the steps the government has taken to reduce transparency and limit criticism of its policies. This includes the Border Force Act (2015), which had a direct impact on the research I planned to undertake for this thesis. Finally, beyond this descriptive account of the issues, I will consider the historical, social and political factors that have led to Australia’s current approach. I will argue that multiple factors have led to the adoption of Australia’s present policies, and these factors need to be understood by those who seek to have an impact on policies governing the treatment of refugees and asylum seekers.

1.2  The Global and Regional Context

In 2016, 65.6 million individuals were forcibly displaced worldwide because of persecution, conflict, violence, or human rights violations. Of these, a third (22.5 million) were refugees and less than 5% (2.8 million) were asylum seekers\(^4\) (United Nations High Commissioner for Refugees [UNHCR], 2017). Industrialised countries, including Australia, host and receive a small proportion of these refugees and asylum seekers.

\(^4\) See previous section for common abbreviations and definitions.
The Asia and Pacific region is home to 9.5 million people of concern to the UNHCR. They include 4.2 million refugees, 2.7 million internally displaced persons and 2.2 million stateless people (UNHCR, 2018). Despite this, there are few protections for those in the Asia-Pacific region. Only 20 of the 45 countries and territories in the Asia-Pacific region have acceded to the 1951 Convention Relating to the Status of Refugees and its 1967 Protocol (UNHCR, 2018). The main countries through which asylum seekers pass to reach Australia, which include Indonesia and Malaysia, are not parties to the Refugee Convention or its Protocol, and do not have national procedures in place for determining refugee status or ensuring that the rights of refugees and asylum seekers are respected (B. Douglas, Higgins, Keski-Nummi, McAdam, & McLeod, 2014). Increasing numbers of asylum seekers and few mechanisms for protection are both factors that have encouraged irregular migration by both land and sea throughout the Asia-Pacific region, and globally.

Australia has invested heavily in the Asia-Pacific region to control irregular migration. In 2002 the Bali process was established to address people-smuggling and irregular migration. This was an Australian initiative that remains funded largely by Australia and Indonesia (Petcharamesree, 2016). A Regional Cooperation Framework and the establishment of a Regional Support Office in Bangkok the following year bolstered the process in 2011. In March 2016, leaders from 41 countries adopted the Bali Declaration on People Smuggling, Trafficking in Persons and Related Transnational Crime. The declaration emphasised the need for greater regional cooperation, increased partnerships and responsibility-sharing, with commitments on reception conditions, predictable disembarkation, and legal pathways for refugees and asylum seekers among other commitments (UNHCR, 2018).

There are good reasons to be sceptical about the intent of these initiatives, however. The Bali process has allowed Australia to “multilateralise” its agenda, with countries throughout the region adopting similar policy (Wesley, 2007). Australia’s involvement in the region has included “securing national borders and controlling people movements through technological innovations, intelligence and policing collaborations, and legislative and policy development; and elaborate arrangements for managing irregular migrants within particular countries” (Larking, 2017, p. 88). In practical terms, this means that the Australian Government has denied

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5 https://www.baliprocess.net
6 In other words, with such diplomacy Australia has influenced multiple countries to push its agenda.
visas to those seeking asylum, intercepted airlines and ships, and manipulated borders (Weber, 2007). Australia has funded reviews of border management systems and provided infrastructure for more effective border management and detention in a number of countries (Nethery, Rafferty-Brown, & Taylor, 2013; Spinks, Karlsen, Brew, Harris, & Watt, 2013; Taylor, 2008). Australia also funds the promotion of its policies, including so-called “community engagement” campaigns and advertisements (Barker, 2014). The Australian immigration department, police and defence force collaborate closely with regional counterparts, both with a physical presence and through intelligence sharing (Barker, 2014; Spinks et al., 2013; Taylor, 2008). The Australian government also provides funding for the International Organisation for Migration (IOM) and the UNHCR to process and support irregular migrants and refugees living in the community in Indonesia, Nauru, Papua New Guinea and Cambodia (Kneebone, 2014; Larking, 2017; Nethery et al., 2013; Taylor, 2008). This influence extends beyond the Asia-Pacific with Australian aid in the middle east and north Africa arguably used to immobilise asylum seekers (Watkins, 2017).

In short, Australia’s policies continue to spread throughout the Asia-Pacific region. Countries that did not routinely detain refugees and asylum seekers are now doing so, in large part due to Australia’s influence (UNHCR, 2015). Australia’s emphasis on policing over protection reflects global trends, but Australia has gone further than other countries by trying to make its borders completely impenetrable (Larking, 2017).

1.3 A Brief History and Overview of Australian Immigration Detention

Australia has re-settled millions of migrants and over 800,000 refugees since federation in 1901 (Refugee Council of Australia [RCOA], 2016). Nevertheless, its largely “controlled” migration and humanitarian programmes have a turbulent and exclusionary history. Mandatory immigration detention, which was introduced in 1992, is the most striking contemporary example of this exclusionary approach. The reasons for introducing mandatory detention were given at the time by Gerry Hand. In his speech at second reading, the then Minister for Immigration, stated:
The Government is determined that a clear signal be sent that migration to Australia may not be achieved by simply arriving in this country and expecting to be allowed into the community ... this legislation is only intended to be an interim measure. The present proposal refers principally to a detention regime for a specific class of persons. As such it is designed to address only the pressing requirements of the current situation. However, I acknowledge that it is necessary for wider consideration to be given to such basic issues as entry, detention and removal of certain non-citizens (Hand, 1992).

Since the introduction of mandatory detention, the Australian government has continuously managed centres on the Australian mainland and has also introduced, repealed and re-introduced offshore processing centres on Manus Island (Papua New Guinea) and Nauru (see figure 1.1 for locations of all major detention centres). Offshore processing was most recently reintroduced in 2012, and those who arrived by boat after 2013 were given no opportunity to resettle in Australia (Rudd, 2013). In October 2015, the Nauru government announced that they would be processing all remaining asylum seekers who would no longer be confined within the detention centre. This was announced only days before an Australian High Court challenge, with the opening of the centre forming a key part of the government’s defence (Davidson & Hurst, 2015; Hurst, 2015a). In April 2016, Papua New Guinea’s Supreme Court ruled that Australian run immigration detention on Manus Island was illegal (Tlozek & Anderson, 2016). The centre was formally closed on the 31 October 2017, however asylum seekers refused to leave, and expressed concerns about their safety in the community. More than 300 men were removed by force by Papua New Guinean Police on the 24 November 2017. Concerns about safety were well founded and since both centres were “opened,” conditions have become increasingly dangerous with violence and a number of attacks already reported (Allard, 2017; Doherty, 2017c). Despite a resettlement deal being struck with the United States, many people remain on Manus Island and Nauru with little or no news on resettlement or safety (Doherty, 2017d).

Asylum seekers and refugees account for a small proportion of Australia’s overall migration and humanitarian programme, and very few arrive by boat (see figure 1.2 for numbers and definitions). As of December 2017, 338 people were held in offshore detention on Nauru,
including 36 children. At the same time, 1,285 people were held in onshore detention (Australian Border Force, 2017b). These numbers are significantly lower than previous years (see figure 1.3). The number of people detained offshore peaked in April 2014, when 2,450 people (including 190 children) were detained on both Manus Island and Nauru. Prior to the introduction of offshore processing there were 9,256 people in onshore immigration detention, including 1,820 children (Department of Immigration and Citizenship [DIAC], 2013a).

Figure 1.1 – Locations of major Australian immigration detention facilities and years of operation

Note. As discussed earlier, Australia has managed immigration detention centres (IDCs), immigration residential housing (IRH), immigration transit accommodation (ITA) and alternate places of detention (APODs)

This figure is somewhat misleading. The immigration department has not reported anyone being detained on Manus Island since the centres official “closure” in October 2017. In the October 2017 statistics, 690 men were reported to be detained there (Australian Border Force, 2017c).
Data adapted from Department of Immigration and Border Protection, DIBP (n.d.); Phillips and Spinks (2012). Notes: The following measures used. “Migration programme outcome” – The immigration department defines this as “the number of visas granted net of Business Innovation and Investment visas cancelled and net of places taken by provisional Partner category visa holders who do not subsequently obtain a permanent visa”. The humanitarian programme is comprised of both an onshore and offshore component. The offshore component has comprised of those who had already been recognised as refugees by UNHCR and were waiting resettlement overseas. The onshore component has been comprised of those who had arrived in Australia and then applied for protection (with this group usually detained). Onshore and offshore components were linked in 1996, meaning that every visa issued onshore would impact the number available for offshore applicants (Karlsen, Phillips, & Koleth, 2011). Numbers taken from Phillips and Spinks (2012) exclude boat crew members (where recorded). The figures cited here for Australia’s migration program are conservative. In reality, the total migration program (permanent and long term temporary visa grants) is much larger than the 190,000 figure often cited. The Australian Bureau of Statistics forecast total migration arrivals for the year ending 30 September 2014 to be 511,500, with a net overseas migration for the same period as 246,300 (B. Douglas et al., 2014).

Figure 1.3 – Onshore immigration detention population

Data adapted from Australian Border Force (2015); Australian Border Force (2016, 2017a); DIAC (2013b); DIBP (2014); Phillips and Spinks (2013). Notes: The table doesn’t include those held in offshore detention. When data has been utilised from immigration detention statistics summaries, detention population as at June 30 that year was used.
1.4 Immigration Detention and the Consolidation of Government Power

Under Australian law, immigration detention is a form of administrative detention, which is to say that it is administered by the executive rather than the judiciary. The Migration Act (1958) and the Migration Regulations (1994) are the two main pieces of legislation that govern Australia’s refugee and immigration policy. This legislation contains little detail about the conditions in which people are detained and how healthcare should be administered. It also makes no distinction between adults, children and other vulnerable people, and there are no limits on the duration of detention. The Australian constitution permits such detention on the condition that it is not used as a form of punishment (Al–Kateb v Godwin, 2004).

There are several important differences between administrative and judicial detention. First, administrative detention occurs without thorough investigation and the judicial elements of a trial and sentencing. Second, from this it follows that administrative detainees are not necessarily detained because of something they have done, but usually because they belong to a certain category of people. Third, administrative detainees are often not informed of the duration of their detention. Fourth, administrative detention is not subject to the same oversight as judicial detention (Nethery, 2010). I will expand upon these points below when discussing the historical, social and political factors that explain Australia’s present policies.

The government has substantial powers in relation to Australian immigration detention, and successive governments have sought to expand this power (Penovic, 2003). Furthermore, the core elements of these policies have received support from both major political parties, as discussed by Grewcock (2013, p. 11):

…both the [then] ruling Labor party and the opposition Liberal-National party coalition share a mutual disdain for the arrival of any new boat bringing refugees into Australian waters, distinguishing themselves only by a willingness to blame the other for allowing such breaches of Australia’s forward defences or indulging in squabbles over the impact of government policy on refugee movements in the region. While this occasionally throws up superficial differences in emphasis about how best to ‘stop the boats’, there is, fundamentally, a high level of bipartisan agreement that unauthorised refugees
should be deterred through measures such as the mandatory and indefinite detention of all unauthorised non-citizens; the use of offshore processing; extensive naval interdiction programmes; and a punitive anti-people-smuggling regime.

The extensive power wielded by government, and the bi-partisan support Australian immigration detention has received has led to a situation where the government has been able to resist political reform and there are few avenues for legal redress. This has long been recognised throughout the legal literature:

the current regime is a perfect storm of procedural disabilities which creates a legal black hole for these refugees. The system strikes at the core of elementary conceptions of the rule of law: the right to know the case against oneself; the right to effectively challenge it; the right of a court to control highly invasive administrative action; and, ultimately, accountability for the proper exercise of public power. This remains true notwithstanding that the refugees are non-citizens, or entered Australia irregularly or may be security risks. Every person has a right to be treated fairly, not peremptorily or summarily, by Australian legal processes — even if there is seemingly little appetite amongst politicians to stick their necks out for those stigmatised as ‘illegal entrants’, ‘Asian foreigners’ and ‘terrorists’ (Saul, 2012, p. 6).

1.5 Secrecy and the Border Force Act

Beyond that discussed above, The Australian government has sought to expand its powers in relation to Australian immigration detention by attempting to limit oversight and increase secrecy in relation to these policies. In particular, the Border Force Act (2015) made it unlawful for clinicians working within the system to speak out about their concerns. I will focus on this piece of legislation and its impact below for two reasons. First, it had a direct impact on empirical research planned as part of this PhD. Second, future responses need to account for the way in which the government has dealt with criticism. The government has sought not only to exercise power over non-citizens by means of administrative detention; it has sought to intimidate and silence all critics. The issues at stake thus also extend to fundamental questions about transparency in a democratic political system (Reilly, Appleby, & Laforgia, 2014).
1.5.1 The Border Force Act

The Border Force Act was passed on 1 July 2015 with bi-partisan support. Part 6 of the Act, entitled “Secrecy”, set out provisions related to disclosure of “protected information”. Under the act all staff (past and present) who work with or within immigration detention were considered “entrusted persons”. Any information obtained during their time working in immigration detention was deemed to be “protected information” and any “record or disclosure” of this information was punishable by up to two years imprisonment.

The government was quick to reassure the public and the healthcare community that the Border Force Act (2015) would not prevent staff from reporting matters of public interest or child abuse (Newhouse, 2015). However, it also required entrusted people to exhaust all internal complaint channels before disclosing information publicly. While there were narrow avenues for disclosure under whistle-blower protection laws, these did not provide protection outside of Australia, and when they did, they did so only in very specific circumstances (Newhouse, 2015). Thus anyone who wished to disclose any information related to their employment had to make complex legal decisions with few guarantees in regards to reporting; so even if information was disclosed in the public interest staff may have been liable to prosecution (Hoang, 2015).

The potential impact of this legislation was immediately recognised by clinicians and the broader healthcare community who responded with defiance and protest. It was not until 30 September 2016 that the government quietly and with little explanation amended the Border Force Act (2015). While a number of professions including social workers and teachers remain subject to the Act, clinicians were exempt from its secrecy provisions. This came prior to an impending high court challenge (which the government appeared to want to head off), in relation to the secrecy provisions of the Act (Doherty, 2016b) and over 12 months after amendments were called for by the Australian healthcare community (Australian Associated Press, 2015a).

Despite attempts by the government to mollify concerns about the Border Force Act (2015) at the time of its introduction, this legislation had an almost immediate impact. In September 2015 the UN Special Rapporteur on the Human Rights of Migrants, Francois Crépeau, postponed his planned visit to Australia due to a lack of cooperation from the government who would not
grant immunity to those who spoke with the UN, leaving them liable to prosecution (Crépeau, 2015). The Act also impeded research into the system of immigration detention, including empirical research that I planned to conduct for this PhD.

1.5.2 The Border Force Act and Its Impact on this Project

This PhD was motivated by my experience working as a Counsellor in Australian immigration detention centres, where I witnessed the impact of prolonged detention on health and the delivery of healthcare. I proposed to study the ethics of healthcare in immigration detention, focusing on the clinical and ethical challenges faced by clinicians who had formerly worked in this setting. I planned to investigate how they managed these challenges, and what the impact of this was on the healthcare delivered to detainees. I enrolled as a PhD candidate in the School of Public Health at the University of Sydney in July 2014. Christopher Jordens agreed to be my research supervisor.

I drafted a research protocol that included anonymous, semi-structured interviews with clinicians who had worked in Australian immigration detention centres. I planned to recruit participants through my own professional networks using “snowball sampling”, and also by identifying clinicians who had spoken publicly about their experiences. At the time this protocol was submitted to the University of Sydney Human Research Ethics Committee (HREC) there was no restriction on former clinicians speaking about their experiences in immigration detention centres.

After feedback from the HREC the application was revised and re-submitted on 16 June 2015. The HREC responded with in-principle support for the study. It also noted the introduction of the Border Force Act (2015) and asked us to comment on the “likely effect (or otherwise) of the new legislation in terms of the feasibility and risk of undertaking this study as originally proposed”. I and my supervisor discussed this with colleagues and concluded that we faced two major issues. One was that interviewees would be with “entrusted persons” under the Act and the information we sought would therefore be deemed “protected information”. Another was that I would also be an “entrusted person” having previously worked as a clinician in immigration detention.
We sought legal advice from The University of Sydney Office of General Counsel (personal communication, 12 October 2015) to determine the viability of the PhD project under the Border Force Act (2015). The advice confirmed the above concerns and noted the broad nature of what may be considered “protected information”. We were told that everything from “highly sensitive” to “highly mundane” matters would be captured under the Act. Thus any disclosure from participants would be likely be considered “protected information” as would the proposed recruitment strategy and the structure of participant interviews because both involved information gained from my previous employment in immigration detention. Potentially, both myself and the interviewees could face a two year gaol term for any disclosure that resulted from the study. Furthermore, The University of Sydney could also be held liable for the acts of its employees including the research supervisor, the director of the research centre, and the Head of School.

The Office of General Counsel concluded that the only way to proceed with this research was to “(a) not interview a current or past Australian Border Force employee or (b) to seek the approval of the Department [of Immigration] to conduct interviews, which would likely curtail any free inquiry”. At that point, we abandoned our plans to conduct the interviews and began to explore other avenues for investigation. By the time the Border Force Act (2015) was amended, it was too late to implement the original research plan, and I resolved to complete the current project instead.

1.5.3 The Ongoing Threat to Healthcare and Research

The Border Force Act (2015) has not been the only means used by the government to wrap the system of immigration detention in secrecy. Journalists have had little to no access to detention centres (Jabour & Hurst, 2014). Police have raided offices of contractors and seized equipment in attempts to find journalists’ sources (Farrell, 2015d, 2015e). The government has also referred journalists and clinicians who have spoken about the conditions within detention centres to the Australian Federal Police (Farrell, 2015c, 2016). Attacks have extended to the Australian Human Rights Commission (AHRC). After the release of the AHCR Forgotten Children Report (2014) the government called for the resignation of the Commission’s President, Gillian Triggs (Borrello & Glenday, 2015)\(^8\). The government has also directed its

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\(^8\) This will be discussed in greater detail in sections below and Chapter 6.
hostility at international organisations. The former Prime Minister Tony Abbott attempted to deflect international criticism by suggesting, “Australians are sick of being lectured to by the United Nations” (Kozaki, 2015, para. 4).

A number of measures have been aimed more directly at healthcare. In late 2013 the government disbanded the Immigration Health Advisory Group (IHAG), an independent group of experts who provided oversight and advice on healthcare within detention centres (Laughland, 2013). The government also attempted to block the release of potentially damaging data by IHMS concerning the mental health of people held in immigration detention (Young & Gordon, 2016). Clinicians and welfare staff have also been stood down from their positions after being accused by the government of fabricating stories of abuse and encouraging asylum seekers to self-harm. These allegations were later proven to be false by The Moss Review (2015), and the government was forced to compensate the former staff (Davidson, 2016).

The government’s hostility to its critics has continued since the amendment of the Border Force Act (2015). Its attempts to silence criticism and limit oversight has also had a significant impact on healthcare more generally, something which I will again discuss in Chapter 3. First however, I will examine how Australian immigration detention has been used as a deterrent, and how this has affected those who have been detained.

1.6 Immigration Detention as a Deterrent

Today, Australian immigration detention and particularly offshore detention has come to function primarily as a policy of deterrence, and this explains why it has come to entail so much deliberate cruelty. Whilst a range of historical, social and political factors have contributed to this development, the introduction, repeal, and reintroduction of offshore processing stand out as three key events.

In August 2001, 433 asylum seekers sent a distress call from their sinking ship. A Norwegian freight ship called the Tampa rescued them. The asylum seekers asked to be taken to Christmas Island off the north-west coast of Australia, but the Australian government refused the Tampa entry to Australian waters. A standoff between the Tampa and the Australian government
ensued until the Captain of the Tampa defied the orders and entered Australian water. The ship was intercepted by Special Air Service (SAS) soldiers to prevent it from reaching land.

On 1 September 2001 the Australian government announced that it had found a “solution” to the Tampa problem and the “Pacific Solution” was born. It had entered into an agreement with Nauru, a small Pacific island and former Australian dependent territory. In exchange for an initial sum of US$10 million in aid, the government of Nauru agreed to house asylum seekers while their claims were processed. The UNHCR would assess the claims of the asylum seekers (Brouwer & Kumin, 2003). In the lead up to the election in October 2001, Australia’s former Prime Minister, John Howard, defended Australia’s increasingly tough approach toward refugees and asylum seekers famously declaring that “we will decide who comes to this country and the circumstances in which they come” (Howard, 2001, para. 12). This speech set the tone for Australia’s immigration policy to this day, with these actions widely thought to have helped Liberal Party win the 2001 federal election under Howard’s leadership (Manne, 2003).

Australia’s policy of offshore processing was repealed by the then Rudd Labor government in 2008. In 2012, however, facing political pressure due to increasing boat arrivals, the Labor Party re-introduced offshore processing. Although the two major Australian political parties employ slightly different rhetoric on this issue, they have both explicitly maintained offshore processing as a deterrent9 (Bowen, 2012; Doran, 2015; Dutton, 2015; Howard, 2001; Morrison, 2014). In re-introducing offshore processing, then Prime Minister Julia Gillard stated that, “there is nothing humane about a voyage across dangerous seas with the ever-present risk of death in leaky boats captained by people smugglers” (Gillard, 2010, para. 64). After the 2013 election then Prime Minister Tony Abbott continued down a similar path, stating that, “[i]n any morality contest, preventing hundreds of deaths at sea surely justifies robust measures to prevent people smuggling” (Abbott, 2015, para. 4) and even promoting these policies as “[t]he most humanitarian, the most decent, the most compassionate thing you can do” (Cox, 2015, para. 7). Upon being confronted by allegations of bribing people smugglers to return asylum seekers to Indonesia, Abbott seemingly doubled down, stating that the government was “prepared to do what is necessary” and that stopping the boats was, “good for Australia, it’s

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9 A number of other policies further act to deter boat arrivals, such as towing asylum seeker boats back to international waters or toward their port of origin (Doherty, 2017a). Many of these measures were discussed above when outlining the global regional context of Australia’s policies.
good for Indonesia and it’s particularly good for all those who want to see a better world” (Medhora, 2015, para. 4) 10.

The upshot of these events is that those who arrived after the re-introduction of offshore processing have been used as examples to deter other asylum seekers from travelling to Australia by boat. Because the government maintains these policies with the explicit aim of deterring boat arrivals, the harms discussed below are not the result of negligence or indifference. This is best summarised by Grewcock (2013, p. 11):

Over the past twenty years, such policies have inflicted a scale of systemic abuse on unauthorised refugees that can justifiably be described as state crime. While this can be illustrated by the extensively documented and entirely foreseeable cases of physical injury, trauma, self-harm and suicide within Australia’s immigration detention centres, the state crime associated with border policing fundamentally rests on the alienation, criminalisation and abuse of those with a legitimate reason to seek entry into Australia and a legitimate expectation that they should be allowed to do so.

One example of the direct and completely avoidable harm caused by the Australian government’s policy of deterrence is the death of Hamid Kehazaei. Kehazaei was an asylum seeker detained on Manus Island who needed to be transferred to the Australian mainland for urgent medical attention after all treatment options on Manus Island had been exhausted. His transfer was delayed, and he died as a direct result of this. The failures that led to this tragedy were long known and completely avoidable. The circumstances of this case are described in more detail in one of the published articles included in the portfolio of publications at the end of this thesis 11. The following section summarises other evidence of the effects of the Australian policy of deterrence on the health, wellbeing and human rights of refugees and asylum seekers who are detained both onshore and offshore.

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10 In recent years, these policies have been increasingly justified on “humanitarian” grounds. This is obviously not the case. In addition to the cruelty of these policies, immigration detention fulfils a number of other needs that are largely incompatible with humanitarianism (as will be seen later in this chapter). The humanitarian border, discussed in Chapter 5, provides further reason to be sceptical.

11 “Ethics, foreseeability, and tragedy in Australian immigration detention” (Essex, 2015a).
1.7 The Impact of Australia’s Policies

1.7.1 The Health and Wellbeing of Detained Asylum Seekers and Refugees

For all refugees and asylum seekers, each stage of the migration journey involves exposure to potentially traumatic experiences including war, violence, torture, persecution and discrimination (Kirmayer et al., 2011; Mölsä et al., 2014; Schubert & Punamäki, 2011; Shannon, Vinson, Wieling, Cook, & Letts, 2015; Song, Kaplan, Tol, Subica, & Jong, 2014). Health status amongst refugees after resettlement is generally poorer than that found in the wider community (Fazel, Karunakara, & Newnham, 2014; Fazel, Reed, Panter-Brick, & Stein, 2012; Fazel, Wheeler, & Danesh, 2005; Johnston, Smith, & Roydhouse, 2012; Keyes, 2000; Reed, Fazel, Jones, Panter-Brick, & Stein, 2012). Post-migration stressors such as uncertainty and insecurity are also harmful to health. Immigration detention is a particularly damaging post-migration stressor (Fazel et al., 2012; Fazel et al., 2005).

Despite the intense scrutiny and controversy that has surrounded onshore and offshore immigration detention, empirical research has been somewhat limited, largely due to restrictions placed on access by the Australian government (as discussed above). Of the studies that exist, all point to immigration detention as being uniquely damaging, having a dramatic impact on mental health and wellbeing.

A survey conducted by an Iraqi Doctor detained at Villawood immigration detention centre in collaboration with a Psychologist working there revealed that among those who had been detained for over nine months, 58% reported exposure to pre-migration trauma including physical torture, and 28% reported the murder or disappearance of immediate family members. A majority of the sample displayed chronic depressive symptoms (85%) and pronounced suicidal ideation (65%). Mental state was observed to deteriorate as the length of time in detention increased. Symptoms included impairment in concentration, pervasive fear and mistrust, repeated instances of self-harm and, in some cases, psychosis. Of the 33 detainees observed, only one displayed no symptoms (Sultan & O’Sullivan, 2001).

In a study of families detained in a remote onshore immigration detention centre, Steel et al. (2004) conducted telephone interviews without the knowledge of the immigration department
or contractors. They concluded that all adults and children met diagnostic criteria for at least one current psychiatric disorder. Among 14 adults, they identified 26 disorders. Among 20 children, they identified 52 disorders. Retrospective comparisons indicated that adults displayed a threefold and children a tenfold increase in psychiatric diagnoses subsequent to detention. The study also noted that trauma was common within immigration detention. All adults and children were distressed about their situation, had intrusive images of events that had occurred in detention, and feelings of sadness and hopelessness.

Other evidence has come from asylum seekers treated in the Australian community. Mares and Jureidini (2004) examined the practical and ethical issues that arose in the assessment of 16 adults and 20 children who were held in detention and referred to a child and adolescent mental health service. They concluded that there were very high levels of mood disturbance and post-traumatic symptoms. All children had at least one parent with a psychiatric illness. Of the 10 children aged 6-17 years all fulfilled criteria for both posttraumatic stress disorder (PTSD) and major depression with suicidal ideation. Eight of the ten children, including three preadolescents, had made significant attempts at self-harm. Seven had symptoms of an anxiety disorder and half reported persistent severe somatic symptoms. The majority (80%) of preschool-age children were identified with developmental delay or emotional disturbance. The authors concluded that a number of these issues were attributable to their experiences in detention.

In a study funded by the immigration department, J. P. Green and Eagar (2010) conducted an analysis of the health records of 720 of people who were detained. This study revealed that there was a clear association between length of detention and poor health. Those detained for over 24 months were found to have particularly poor physical and mental health. Asylum seekers also had more health problems than others held in detention. Other researchers have also turned to medical records to gain insight into the impact of detention. Bull, Schindeler, Berkman, and Ransley (2013) reviewed 419 Commonwealth Ombudsman reports over a four year period relating to individuals who had been in immigration detention for longer than 24 months. Rates of both physical and mental illness were extremely high. In 252 cases (of which

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12 This study does not specify whether the population was detained in onshore or offshore detention, however only a small number of participants were classified as boat arrivals, thus majority if not all were likely to have been detained onshore.

13 This study also does not specify whether the population is detained onshore or offshore.
179 were professionally confirmed), 65% per cent reported problems with physical health and 60% reported mental health problems. Approximately 21% reported problems with both mental and physical health. Two thirds of those with mental health problems showed signs of depression, which was the most common diagnosis. Approximately 40% of people had experienced suicidal ideation. About 30% experienced sleep difficulties and anxiety respectively, and a quarter reported PTSD and actual self-harm. There was a direct link with the length of detention, although this was not just unidirectional with one quarter of cases having mental and physical health concerns explicitly linked to difficulties engaging in the migration process and delays in final refugee determinations. This extended the period of detention between three to five months. In 54% of cases detention was identified as causing – or being among the causes of, or exacerbating – health problems, both mental and physical.

The AHRC Forgotten Children Report (2014) examined children’s health and wellbeing and the impact of onshore and offshore immigration detention. It found that “[t]he mandatory and prolonged immigration detention of children is in clear violation of international human rights law” and that immigration detention was having “profound negative impacts on the mental and emotional health of children” (p. 29). In relation to offshore detention on Nauru, the report found that, “[c]hildren detained indefinitely on Nauru are suffering from extreme levels of physical, emotional, psychological and developmental distress” (p. 13). In a follow up study, Young and Gordon (2016) re-examined the data collected by the AHRC on 25 onshore detention centres. They concluded that length of time detained was associated with higher self-reported depression scores, with females more vulnerable to length of time in detention. Approximately half of the individuals were identified as having symptoms of PTSD on clinician-rated measures. One-third of the children, adolescents and adults suffered with clinical symptoms requiring tertiary outpatient assessment. This investigation re-enforced the long established impact that immigration detention has on children and families. For example, almost 10 years earlier a clinician told the People’s Inquiry into Immigration Detention (Australian Council of Heads of Schools of Social Work [ACHSSW], 2006, p. 49):

You couldn’t really design an environment more destructive to child development than immigration detention. The parents are all crippled by their experiences to a point where

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14 That is, length of detention resulted in generally worse mental health, with generally worse mental health resulting in longer periods detained.
every case that we are involved in was notified to the local state welfare child protection services and in every case the child protection services found that abuse was proven. Sometimes that was all at the hands of the detention centre, but also often it was at the hands of the parents who we have no reason at all to believe were anything less than competent parents at the time that they arrived in the country, but by virtue of the detention experience they’ve had they have been so damaged that they are either incapable of caring for their children or were actively damaging them. I guess the other main abuse that the children were subject to was the witnessing of unrelenting violence, not just the spectacular stuff that happened during the riots but people cutting themselves and writing their names in blood and the kinds of comments that their parents were making to them, like you know “I’m dead, do your best to be a good girl and get on with your life,” that kind of stuff.

Other studies and investigations have examined self-harm and suicidal behaviour in immigration detention. Men’s and women’s rates of suicidal behaviours in Australian immigration detention centres were estimated to be approximately 41 and 26 times the national average respectively (Dudley, 2003)\(^{15}\). The Commonwealth Ombudsman (2013) conducted the most comprehensive investigation into self-harm in onshore immigration detention to date. This report found that between January 2011 and February 2013 there were 4,313 incidents of actual, threatened and attempted serious self-harm recorded in immigration detention facilities in Australia. In the 2012-2013 financial year there were 846 incidents of self-harm across the immigration detention network. This report found links between mental illness, self-harm and a number of aspects of the detention environment and immigration policy. This included levels of previous trauma, fears for family who may have been left behind, isolation, the detention environment itself, including a lack of autonomy, disempowerment and overcrowding. Furthermore, the detention environment itself promotes self-harm beyond the individual with groups of people who are often experiencing frustration, distress and/or mental illness causing a “contagion” effect, resulting in the spread of “maladaptive behaviours” (Commonwealth Ombudsman, 2013). Both of the above investigations acknowledge a number of limitations, mainly related to data not being available or incomplete, making comparisons difficult between rates of self-harm and suicidal behaviour in immigration detention and the general community. In addition to this at least 1,997 deaths related to Australia’s policies have been recorded from

\(^{15}\) This study does not specify whether the population was detained in onshore or offshore detention.
2000-2017 (The Border Crossing Observatory, n.d.). Of these deaths, 49 have occurred within Australian immigration detention centres and 32 have been due to suicide or suspected suicide\textsuperscript{16}. This includes those who have drowned or been reported missing at sea. While those who died after forced return to their country of origin are recorded, these deaths are likely to be underreported because of difficulties in obtaining data.

From the above discussion it may already be obvious that very little empirical literature exists that specifically looks at the impact of offshore detention. While there is overwhelming anecdotal evidence to suggest offshore detention has a far more devastating impact, a lack of empirical evidence is not surprising, largely because of the steps the government has taken to promote secrecy (described earlier in this chapter). One of the articles included in my portfolio of published work attempts to fill this gap, by summarising the particularly harmful aspects of offshore detention along with its impact on health and healthcare\textsuperscript{17}. Similarly the impact of other detention environments, such as APODs, has also been overlooked. Another article included in my portfolio\textsuperscript{18} explores the impact of APODs on the health and wellbeing of children and families\textsuperscript{19}. The article argues that while APODs offer a number of superficial improvements to other forms of detention (such as IDCs), these environments do little to buffer the harms promoted by Australia’s policies, as many of the issues identified in the empirical literature are also problems in these environments. The article concludes that children and families therefore should not be detained in any form of held detention.

1.7.2 Human Rights and International Law

Australian immigration detention not only damages the health and wellbeing of asylum seekers; it violates human rights that are enshrined in numerous treaties and international instruments to which Australia is signatory. This issue was raised in the AHRC Forgotten Children Report (2014). The UNHCR has also issued numerous statements, reports and submissions that have raised concerns about the human rights implications of Australia’s

\textsuperscript{16} Not all suicides occurred within immigration detention centres, some occurred in the community or upon forced return to country of origin.

\textsuperscript{17} “Healthcare and clinical ethics in Australian offshore processing centres” (Essex, 2016b).

\textsuperscript{18} “Mental health of children and families in Australian alternate places of immigration detention” (Essex & Govintharajah, 2017).

\textsuperscript{19} The AHRC Forgotten Children Report (2014) also highlighted the impact of these environments, however understandably focused on children and families detained on Nauru.
policies. These concerns relate to offshore processing, refoulement\textsuperscript{20}, boat turn backs and the conditions of detention, among other concerns (AHRC, 2017; UNHCR, 2013a, 2013b, 2013c).

In late 2014, the UN High Commissioner for Human Rights raised concerns about Australia’s policies of offshore processing and boat turn-backs, noting that these were “leading to a chain of human rights violations, including arbitrary detention and possible torture following return to home countries” (Al Hussein, 2014, para. 48). Shortly after, the UN Committee Against Torture released its periodic review which again cited concerns about offshore processing (United Nations Committee against Torture, 2014). In 2015 the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment found that Australia’s policy of offshore processing had systemically violated the Convention Against Torture (UN General Assembly, 1984), violating the right “to be free from torture or cruel, inhuman or degrading treatment.” (Mendez, 2015, p. 8). During Australia’s second Universal Periodic Review by the Human Rights Council, over 50 states raised concerns about Australia’s policies. Mandatory indefinite detention, the detention of children, offshore processing and boat turn-backs all received significant attention (UN Human Rights Council, 2016). In 2016 the United Nations called on Australia to end the practice and processing of people offshore, after the Nauru files\textsuperscript{21} were released (The Guardian Australia, 2016; UN, 2016).

This discussion is by no means exhaustive. The Australian Government’s policies have come under sustained criticism from a number of other human rights organisations, such as Amnesty International (2013, 2016). There is also an extensive literature on human rights and international law which has been no less critical (Saul, 2012). I will return to the issue of human rights again in Chapter 2.

\textsuperscript{20} The principle of non-refoulement has been defined in a number of instruments, for example, the Convention Relating to the Status of Refugees (UN General Assembly, 1951, art. 33) states: “No Contracting State shall expel or return (“refouler”) a refugee in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion”.

\textsuperscript{21} The Nauru files were the largest collection of documents to be leaked in relation to Australian immigration detention (The Guardian Australia, 2016).
1.8 Understanding Australian Immigration Detention

While the first half of this chapter outlined Australia’s policy of mandatory immigration detention, it did little to explain why the Australian government has implemented and continues to pursue these policies. There has been surprisingly little research on this question. Accounts of Australia’s approach have often only been descriptive (as was the first half of Chapter 1) or at best been piecemeal, focusing on different elements that contribute to these issues, for example, individual attitudes toward asylum seekers. Nethery (2010) provides the most comprehensive and cohesive explanation of why the Australian government has implemented and continues to pursue its policy of immigration detention. The sections below draw heavily on her research.

Nethery (2010) employs a range of theory to offer three broad explanations. The first locates Australian immigration detention within the history of administrative detention, charting a lineage of similar forms of detention. Social theories of classification and control explain what she calls the “how”, “who” and “why” of administrative detention. Explanations are also found in the contemporary politics of Australian immigration detention. She argues that it functions to assuage actual and perceived anxieties about identity, the impact of globalisation, and economic security for Australian citizens. I will discuss key elements of this thesis below, along with its implications for my research question, how clinicians should respond to Australian immigration detention.

1.8.1 A Brief History of Administrative Detention in Australia

Present day policies of immigration detention can be situated within a broader history of exclusion in relation to migration. Even if they are related, however, exclusion and detention are not equivalent (Bashford & Strange, 2002). Nethery (2010) and Bashford and Strange (2002) argue that Australian immigration detention is not a new phenomenon, and they highlight a number of similarities and continuities with other forms of administrative detention which have been used since European settlement in Australia. Drawing on the examples of Aboriginal reserves, quarantine stations, and enemy alien internment camps, Nethery (2010) identifies five distinguishing features of administrative detention. The first is “the discourse surrounding, and justifying, the incarceration. In each case, the administrative detention was
implemented in an atmosphere of moral panic” (p. 124). The second feature is that “each form of administrative detention, also, was very much an act of Executive power. The courts played no function in determining who was to be incarcerated” (p. 124). Thirdly, administrative detention “demonstrate[s] the complex and qualified nature of belonging in Australian society” (p. 124). In other words, throughout history, different groups at different times—even those who were Australian citizens or naturalised Australians—have been positioned as ‘others’. Nethery (2010) concludes that, “[a]t this point, incarceration becomes a form of communication to these categories of people to the effect that no matter what they do to demonstrate commitment to Australian society, by virtue of their race, they will never fully belong” (p. 124-125). Fourthly, administrative detention maintains boundaries, both social and geographic. In some cases detention means “controlled people who were already on Australian territory by removing them from society” (p. 125). In other cases it was used to stop individuals external to Australia. In some cases it was used to achieve both: “By removing certain categories of people already living in the community, and by controlling and regulating those who wished to enter, administrative detention functioned to regulate who was permitted to be part of [the] Australian community” (p. 125). Finally, administrative detention has functioned to exclude from society with the permanency of this exclusion often being arbitrary\textsuperscript{22}. Nethery (2010, p. 123) concludes that:

The study of administrative detention in Australia is ultimately the study of the classification of people into social groups, the identification of some of these groups as outsiders to Australian society, and the attempt by governments to control and regulate these groups. Implicit in this process is the notion that there is an ideal Australian identity, and the categories of people subject to administrative detention diverge from this identity in some way.

1.8.2 Theories of Incarceration, Classification and Control

In explaining the social and political functions of administrative detention, Nethery (2010) draws on a number of literatures to highlight three key aspects of Australian immigration

\textsuperscript{22} Drawing on historical examples, Nethery (2010, p. 126) suggests that, “cases of release occurred alongside cases where people were permanently excluded” and that the decision making in relation to who was released appeared arbitrary. However this was also influenced by a number of factors including “the degree of moral panic or other (including more humanitarian) domestic social pressures, concerns about race, national security, demand for labour, risk of infection, and international pressure” (p. 126).
detention: incarceration, classification and control, explaining what she calls the “how”, “who” and “why” of administrative detention.

What purpose does Australian immigration detention serve?23 Australian immigration detention serves a number of functions, such as re-socialising (Goffman, 1961) and shaping the behaviour of those detained (Foucault, 2012). Detention centres have all the features of a total institution (Goffman, 1961) and achieve control in a number of ways. They are geographically isolated, placed in remote parts of Australia, urban outskirts or remote foreign islands. They also have many of the architectural features of prisons and concentration camps (McLoughlin & Warin, 2008) which serve to further dehumanise and alienate those detained, and reinforce their status as outsiders and the control that the government exercises over them.

Incarceration also fulfils the needs of the broader community. For Rothman (1971) incarceration endures even though it often does not fulfil its intended objectives. It endures because it functions to shield society from “disorder and contamination” serving the broader community rather than those detained. Reilly et al. (2014, p. 164) suggest that immigration detention allows the Australian community to look away, providing “the public with welcome relief from the seemingly endless tales of suffering”. Beyond shielding society, incarceration fulfils a number of other important social functions including creating and managing delinquent populations (Foucault, 2012; Garland, 2001). As discussed by Nethery (2010, p. 139):

… the modern nation state is unable to provide security for its citizens in any real sense. What it can provide, in lieu of security, is punishment. The closest thing to providing security – the incarceration of groups of people likely to threaten security – is, conveniently, achieved with the same process as punishment. Moreover, in the modern neo-liberal nation state, imprisonment is easier than solving the problem of marginalised sections of the population at their source.

Immigration detention in Australia serves to re-enforce an increasingly punitive approach taken toward asylum seekers and refugees. It provides a “spectacle” (McNevin, 2007) that shows the government is in control, and it re-enforces narratives of illegality, illegitimacy and threat. Weber (2007) suggests that the spectacle of Australian immigration detention and particularly

23 Or in Nethery’s (2010) words, how does Australian immigration detention achieve its ends?
offshore processing has “nation-binding value”. Thus, incarceration is appealing for a number of reasons: it is easy to implement; it often generates little political opposition, and it reinforces common sense ideas about disorder and blame and therefore can claim to “work”.

Theories of classification explain who is detained in Australian immigration detention. While the majority of asylum seekers who have arrived by boat have been detained, other groups also need to be accounted for, including those who have overstayed or had their visa cancelled. Classification provides a complementary approach to racialised explanations of Australian immigration detention. Nethery (2010) contends that racialisation does not fully explain Australia’s approach toward administrative detention, nor does it adequately explain why some individuals are detained and others who are seemingly similar are not. Neither does it explain Australia’s larger migration program or its offshore resettlement of refugees. This view is supported by a number of other authors (Glynn, 2016; Haslam & Holland, 2012; Pedersen & Hartley, 2015). Nethery (2010) draws on Durkheim, Solovay, Mueller, and Catlin (1938) to explain the production of social outsiders and M. Douglas (1966) theory of social relations and classification. Together these explain why those detained are seen as outsiders, why they are a perceived threat to society and why detention may be understood as a response to this.

M. Douglas (1966) argues that societies develop classifications based on notions of cleanliness and purity. Social order is therefore achieved through classification. There are however vulnerabilities and ambiguities in this system if it is breached, and this threatens social stability or creates “social pollution”, of which there are four types:

The first is danger pressing on external boundaries; the second, danger from transgressing the internal lines of the system; the third, danger in the margins of the lines. The fourth is danger from internal contradiction, when some of the basic postulates are denied by other basic postulates, so that at certain points the system seems to be at war with itself (M. Douglas, 1966, pp. 151-152).

Applying this to Australian immigration detention, asylum seekers who apply for protection, whether they arrive by boat or plane, breach “external boundaries” which should result in

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24 Not to be confused with offshore processing. Australia has resettled about 13,000 refugees a year who are registered with the UNHCR overseas (Karlsen et al., 2011).
automatic exclusion. These individuals are also waiting to be classified. They may be eligible for protection, however, so their status will remain ambiguous until this time. For those already in the Australian community who have had their visa cancelled, Douglas’ (1966) theory accounts for their detention as constituting a “danger in the margins”. Thus people are subject to immigration detention as “they evade clear classification, or because they threaten social order from the inside” (Nethery, 2010, p. 163). This is also supported by discourse studies that have identified a “preoccupation with…categorisation of people” (Rowe & O’Brien, 2013, p. 173).

Finally, Nethery (2010) argues that the main social and political function of administrative detention is control. The government re-enforces perceived control through a number of means other than incarcerating and classifying people. Cohen’s (1972) theory of moral panic gives greater insight into the discourse surrounding Australian immigration detention and how this may then be used to control certain groups. A moral panic occurs when: “A condition, episode, person or group of persons emerges to become defined as a threat to societal values and interest; its nature is presented in a stylized and stereotypical fashion by the mass media and politicians” (Cohen, 1972, p. 9). A moral panic usually results in changes to the law to deal with what has become defined as “deviant” (G. Martin, 2015a). The theory of moral panic is not only useful to highlight how minor events provoke disproportionate responses, but also how these responses may be manipulated to serve greater social and political interests (Nethery, 2010).

How might a moral panic lead to incarceration? Feeley and Simon (1992) argue that the role of the judicial system has shifted to one of managing risk, which has resulted in the targeting of groups. This becomes even more apparent in administrative detention, the primary function of which is to assess, classify and manage groups of people. Furthermore, when a group is detained they are more likely to be a marginalised group (Wacquant, 2001).

In the Australian context, control is reflected in the increasing executive power and the extra-legal nature of immigration detention, particularly in offshore centres (Australian Parliamentary Select Committee, 2015). Themes of control have been present in political rhetoric and debates for some time (McKenzie & Hasmath, 2013). As Cronin (1993, p. 87) notes the government frequently offers “control rhetoric” while the opposition highlights “control failings”. Re-enforcing the importance of examining Australian immigration detention
historically and as part of a larger administrative detention regime, Nethery (2010, pp. 147-148) concludes:

The development of administrative detention, like judicial incarceration, is a response to perceived social, economic and political problems, particularly in times of rapid social change or crisis. Like judicial incarceration, administrative detention persists because it fulfils certain functions for those on the outside, and not because of what it achieves for those incarcerated… Administrative detention does not purport to benefit those detained, and functions only for confinement and exclusion… Another key difference is that administrative detention incarcerates groups of people, rather than individuals. [In order to be subject to administrative detention, o]ne is not convicted, put on trial and sentenced for a particular act… Instead, people are incarcerated because they belong to a certain category… Immigration detention in Australia is an attempt to control entry into the population. It is a response to social, economic and political problems attributed to people who are ethnically or racially different.

1.8.3 The Contemporary Politics of Immigration Detention in Australia

While the above theories provide a broader account of immigration detention, they cannot fully account for the treatment of asylum seekers and refugees, particularly those who have arrived by boat. This group is subjected to the most harsh and exclusionary treatment. There are a number of other theories and concepts that provide additional insight into this. Nethery (2010) suggests racialisation, fear of invasion, globalisation and economic insecurity are key to understanding this.

Racialisation has an ongoing impact on Australia’s approach toward refugees. This has a historical basis, in Australia’s immigration policies, from White Australia to the rise of the anti-immigration One Nation party in the 1990s and its recent resurgence in 2016 (Perera & Pugliese, 1997). While taking a number of forms, racialisation remains present in rhetoric and policy to this day, serving to perpetuate historical exclusion (Every & Augoustinos, 2007). Nethery (2010) highlights a thought experiment:

Imagine that in the next few months political conditions in Zimbabwe forced hundreds of white farmers and their families to flee their country without papers or passports.
Imagine that the farmers left their wives and children in camps in a contiguous African country and flew to Australia unlawfully. Imagine that on arrival they were detained, despatched at once to the detention centres at Port Hedland and Woomera, kept ignorant of their legal rights and not granted access to a lawyer, and were required to remain in the centres for very many months, uncertain of their fate. Imagine, finally, that they were eventually released, granted a temporary protection visa, refused access to services available to first-class refugees, informed that they had stolen places from people more genuinely in need and forbidden to apply for reunion with the wives and children they had left behind in the squalid setting of an African refugee camp ... [an Australian government] would face overwhelming national outrage (Manne, 2001, p. 78).

This is no longer a thought experiment. In March 2018, former Immigration Minister, Peter Dutton, suggested Australia should fast-track white South African farmers’ claims for protection because of the “horrific circumstances” they faced. These calls came at a time when South Africa was attempting to pursue legal changes to allow the redistribution of farm land to black South Africans without compensation (Karp, 2018). The persecution which the government claimed existed was blatantly false (Royal Melbourne Institute of Technology, Australian Broadcasting Corporation [RMIT ABC] Fact Check, 2018). Other reasons were given as to why “a civilised country like [Australia]” should help (Karp, 2018, para. 6). Dutton went on, stating, “[w]e want people who want to come here, abide by our laws, integrate into our society, work hard, not lead a life on welfare. And I think these people deserve special attention and we’re certainly applying that special attention now” (Karp, 2018, para. 8).

Despite this fairly blatant example, racialisation alone does not explain Australia’s response to asylum seekers and refugees. Nethery (2010, p. 60) explores what she calls a “more complex, deep-seated fear of invasion into the Australian psyche”. She contends that this can be attributed to two keys aspects of Australia’s history. Firstly Australia’s colonial past, based on the doctrine of Terra Nullius has meant that territory in Australia has always been contested, creating a latent fear that it will one day be reclaimed (Burke, 2008). Secondly, Australia’s

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25 European settlers considered Australia terra nullius when settlement began in 1788. Terra nullius refers to “land that is legally deemed to be unoccupied or uninhabited” in Latin it can be translated as “land belonging to no one” (“Terra Nullius,” n.d.).
geographical location places it as an “outpost” of Asia leaving it vulnerable to invasion. Both of these factors have led to what Papastergiadis (2006) has termed an “invasion complex”.

A number of analyses have demonstrated how political rhetoric and the media have both manipulated and perpetuated fear of asylum seekers and refugees, particularly those who arrive by boat (Austin & Fozdar, 2016; Bleiker, Campbell, Hutchison, & Nicholson, 2013; Cooper, Olejniczak, Lenette, & Smedley, 2016; Ellis, Fulton, & Scott, 2016; Leach, 2003; Lueck, Due, & Augoustinos, 2015; Maley, 2003; McKay, Thomas, & Warwick Blood, 2011; McLaren & Patil, 2016; Pickering, 2001). This fear is disproportionate; it has little basis in reality (Burke, 2008), and it has been constructed and used strategically by politicians to achieve policy objectives. Lawrence (2006, p. 40) argues:

In deliberately portraying asylum seekers as a threat, the Howard government succeeded in gaining traction for the bizarre notion that desperate people in leaky boats were somehow a threat to our national security. It counted on being able to arouse our fear of being overwhelmed by strangers envious of our good fortune. Perhaps our own deep knowledge that we are alien invaders who have stolen the land we occupy allowed them to feed this anxiety.

In addition to racialisation and a fear of invasion, McNevin (2007) and Hage (2003) offer a further perspective on Australia’s approach toward asylum seekers and refugees. Even though each takes a different approach to the issue, they both highlight anxiety arising from economic insecurity due to globalisation and open borders. A recent example of this came when the former Immigration Minister, Peter Dutton, attempted to exploit such concerns by claiming that illiterate and innumerate asylum seekers and refugees would be taking Australian jobs (Karp, 2016a). While this is likely to play a role in explaining Australia’s present approach and remain a tool for politicians, recent surveys have suggested that levels of unemployment and negative views on immigration were inversely correlated. This suggests that a range of other factors are likely more influential (Markus, 2014).
1.9 Conclusions

Australian immigration detention has been widely criticised. It violates human rights and international law and does immense harm to those detained. While Australian immigration detention serves a number of purposes, more recently and particularly in the case of offshore detention, policies have been engineered as a deterrent. Thus, the suffering and harm created is deliberate and completely avoidable. Furthermore, its status as administrative detention and the government’s ongoing attempts to consolidate power and attack critics raise fundamental questions about power, accountability and transparency in a democratic political system. The reasons as to why Australia has continued to pursue these policies despite this harm and persistent criticism cannot be reduced to a single simple explanation. There are a number of historical, social and political reasons as to why this system has evolved, and the functions it serves, any future response should be mindful of these.
Chapter 2  What Standards Should Australia be Held To?

2.1 Overview

What standards should Australia uphold in its treatment of asylum seekers and refugees? In present discussions this question is often overlooked. While there are a number of commonalities amongst clinicians and healthcare bodies, all have different positions concerning both the level of healthcare that should be provided within immigration detention and the type of broader reform that should be pursued. There are two other important reasons to make these standards explicit. One is to guide action that aims for change in the future, and the other is to provide a point of reference against which such actions can be evaluated.

In this chapter I will outline my position on what standards Australia should be held to. My position is simple: Australia should pursue policy that is consistent with the international commitments it has made. Human rights provide a widely accepted platform on which to base such standards. Australia is signatory to all major human rights instruments, and as internationally accepted norms, human rights provide both an intrinsic and instrumental rationale for action. They provide clear standards for policy, and all major professional healthcare bodies acknowledge their importance along with clinicians’ responsibility to uphold and advance them. Importantly, these standards shift the focus of action from health and healthcare to rights and justice. This is based on the recognition that health is dependent on human rights first being upheld and that human rights cannot be upheld in Australian immigration. Future action should therefore not just be confined to improving the health and wellbeing of those detained within current restraints. Future action should primarily aim to achieve systemic, social and political change consistent with the standards outlined in this chapter.

I propose ten standards related to the health and wellbeing of detainees, the reform of onshore detention and the reform of Australia’s regional approach. I will discuss the basis for each of these standards in human rights and international law. Finally, I will argue that human rights

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26 I will discuss this in Chapter 3.
should be seen as more than an exercise in legal reform. Human rights can also be shaped and realised through grassroots, collective action.

2.2 A Rights Based Approach

Human rights provide a widely accepted platform on which to base standards for Australian immigration detention. As internationally accepted norms, human rights provide both an intrinsic and instrumental rationale for standards of action (UN Office of the High Commissioner for Human Rights [OHCHR], 2006). Additionally they provide a common ground and place of divergence for future discussions and action, and a benchmark against which current and future activity can be measured.

The obligation for clinicians to uphold human rights is clear: rights are emphasised in all major professional codes and guidelines (Australian Medical Association [AMA], 2015; Australian Psychological Society [APS], 2011; Public Health Association of Australia [PHAA], 2015; Royal Australian College of Physicians [RACP], 2015; Royal Australian and New Zealand College of Psychiatrists [RANZCP], 2016). Furthermore, the close relationship between health and human rights means “health cannot be fully enjoyed without the dignity that is upheld by all other human rights” (World Health Organization, 2017, p. 4) and vice versa.

Australia was a founding member of the UN and played a prominent role in the negotiation of the UN Charter in 1945 (AHRC, n.d.). Australia was also one of eight nations involved in drafting the Universal Declaration of Human Rights (UN General Assembly, 1948). Australia has agreed to be party to all major human rights treaties, including the following:

- International Covenant on Civil and Political Rights (ICCPR) (UN General Assembly, 1966a)
- International Covenant on Economic, Social and Cultural Rights (ICESCR) (UN General Assembly, 1966b)
- International Convention on the Elimination of All Forms of Racial Discrimination (CERD) (UN General Assembly, 1965)
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (UN General Assembly, 1979)
• Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) (UN General Assembly, 1984)
• Convention on the Rights of the Child (CRC) (UN General Assembly, 1989a)
• Convention on the Rights of Persons with Disabilities (CRPD) (UN General Assembly, 2007)
• Convention relating to the Status of Stateless Persons (UN General Assembly, 1954)
• Convention on the Reduction of Statelessness (UN General Assembly, 1961)
• Convention relating to the Status of Refugees (UN General Assembly, 1951)
• Protocol relating to the Status of Refugees (UN General Assembly, 1967)

Additionally, Australia has ratified the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UN General Assembly, 2002), the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (UN General Assembly, 2000d), and the Protocol against the Smuggling of Migrants by Land, Sea and Air (UN General Assembly, 2000c). Australia has also ratified the first two optional protocols to the Convention on the Rights of the Child (UN General Assembly, 2000a, 2000b), and the Second Optional Protocol to the International Covenant on Civil and Political Rights (UN General Assembly, 1989b).

Australia has also ratified the Convention on the Law of the Sea (UN General Assembly, 1982), which establishes the structure of maritime territory and the rights and obligations of states. It has acceded to the International Convention on Maritime Search and Rescue (International Maritime Organization, 1979), which establishes State duties in relation to establishing search and rescue services, and the International Convention for the Safety of Life at Sea (International Maritime Organization, 1974), which builds on the norms that States and other actors have an explicit duty to meet for those in distress at sea.

This commits Australia, at a minimum, to respect and cooperate on human rights internationally and in certain circumstances, protect human rights extraterritorially (OHCHR, 2015). All standards below are supported by these instruments and are thus asking nothing more of Australia than to adhere to the commitments it has already made.

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27 Given Australia’s active role in the development of many of these instruments and standing in the international community, a reasonable argument could be put forth as to why it should do more than the minimum proposed here.
2.3 Human Rights and Systemic, Social and Political Reform

Human rights not only provide a widely accepted platform for action and direction as to what change should be pursued, they also provide insight into the type of reform that should be pursued. Importantly the standards outlined below shift the focus of action from health and healthcare to rights and justice. In this respect these standards should be seen to inform action aimed at bringing about systemic, social and political change in relation to Australian immigration detention. This is based on the recognition that health is dependent on human rights first being upheld and that human rights cannot be upheld in Australian immigration detention (OHCHR & WHO, 2008). While discussions in relation to health and healthcare within detention remain important, health and wellbeing will not be significantly improved without broader systemic, social and political change. I have not solely focused on the reform of healthcare within immigration detention for this reason. This has been long recognised in the current literature concerned with healthcare in Australian immigration detention and will be discussed in greater detail in Chapter 3.

2.4 Human Rights Standards for Australia’s Approach to Refugees and Asylum Seekers

What might more specific standards look like? Below, I propose ten standards that relate to three broad areas: the health and wellbeing of detainees; the conditions of detention, and the reform of onshore detention and Australia’s regional policies and offshore detention. These standards will be informed by three documents that outline human rights standards for immigration detention: The AHRC Human Rights Standards for Immigration Detention (2013), the International Detention Coalition Legal Framework and Standards Relating to the Detention of Refugees Asylum Seekers and Migrants (2011) and the UNHCR Guidelines on the Applicable Criteria and Standards Relating to the Detention of Asylum-Seekers and Alternatives to Detention (2012).

28 This comes from the broader recognition that human rights are universal, indivisible, interdependent and interrelated (UN General Assembly, 1993).
29 And as will be seen I have included a standard specifically addressing this.
They will also be presented with the human rights and international legal instruments that support them in table 2.1. For simplicity, this will be limited to what could be called “hard law” that Australia has either ratified or acceded to. There are a range of other recommendations, reports and decisions that support the standards proposed below, however these are too numerous to include. A more exhaustive list can be found in each of the above documents, which provide a much broader application of international instruments and guidance.

Finally, there is the potential for disagreement on how such instruments are interpreted and applied. Discussion of matters of international jurisprudence are important but are unnecessary for the purposes of this thesis. The standards outlined below are clear, straightforward and, for those who respect human rights, widely accepted. They are also consistent with each of the guidance documents related to immigration detention outlined above. Future action should aim to achieve systemic, social and political change consistent with the standards outlined below:

1. All detainees have “the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services” (UN General Assembly, 1948, art. 25). This includes both the right to timely and appropriate care and the underlying determinants of health, such as adequate sanitation, nutrition and housing, healthy environmental conditions, and access to health-related education and information.

2. Detention should not be arbitrary. Decisions to detain should be based on an assessment of individual circumstances and must be exercised in accordance with fair policy and procedures and subject to regular independent judicial review.

3. No one should be subject to indefinite detention. Indefinite detention is arbitrary. Detention should be for the shortest possible time with defined limits on the length of detention, which are strictly adhered to.

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30 This includes treaties, covenants, conventions, charters and protocols, as opposed to “soft law” which includes “General Assembly resolutions, reports of the various bodies of the Office of the High Commissioner for Human Rights (OHCHR), guidance and reported issued by the treaty monitoring bodies and advisory opinions issued by the International Court of Justice (ICJ)” (International Detention Coalition, 2011, p. 4).

31 Many of these objectives will be applicable to both onshore and offshore detention (despite these standards also calling for the closure of offshore detention).
4. There should be a presumption against detention, and if used, it should be used as a last resort; and it must be necessary and proportionate to a legitimate purpose (i.e., identity and security checks, prevention of absconding or compliance with an expulsion order).
5. Vulnerable individuals should not be detained. This includes children, pregnant women, nursing mothers, survivors of torture and trauma, trafficking victims, stateless persons, elderly persons, the disabled or those with physical or mental health needs.
6. Where a person is subject to detention, alternatives must first be pursued. The Australian government should introduce alternatives to detention that ensure the protection of the rights, dignity and wellbeing of individuals.
7. Conditions of detention should comply with basic minimum human rights standards\(^{32}\). There must be regular independent monitoring of places of detention to ensure these standards are met.
8. Australia should reform its approach to irregular migration throughout the Asia-Pacific region. While the Australian government has a legitimate interest in controlling irregular migration and even an obligation to “prevent and suppress the smuggling of migrants by sea” (UN General Assembly, 2000c, art. 7) this does not affect rights and responsibilities of states in relation to the Convention and Protocol relating to the Status of Refugees (UN General Assembly, 1951, 1967), including the principle of non-refoulement (UN General Assembly, 2000c). Furthermore, “detention policies aimed at deterrence are generally unlawful under international human rights law as they are not based on an individual assessment as to the necessity to detain” (UNHCR, 2012, p. 7)\(^{33}\).
9. Boat turn-backs of asylum seekers and refugees should cease. There is also an obligation to rescue vessels in distress\(^{34}\).
10. Offshore detention centres should be closed and those detained there should be resettled in Australia. In addition to violating almost all of the standards discussed above, offshore detention discriminates against asylum seekers who arrive in Australia by boat, which is an issue in itself.

\(^{32}\) The AHRC Human Rights Standards for Immigration Detention (2013) provide the most detailed guidance regarding the conditions of immigration detention. These include details about healthcare within immigration detention, food, clothing, education, accommodation and staffing among other standards.

\(^{33}\) Also see: UNHCR Conclusion on Protection Safeguards in Interception Measures (2003).

\(^{34}\) Also see: International Maritime Organization Guidelines on the Treatment of Persons Rescued at Sea (2004).
Table 2.1 - Proposed standards and supporting international instruments

<table>
<thead>
<tr>
<th>Standards relating to the health and wellbeing of refugees and asylum seekers</th>
<th>Supporting Human Rights and International Legal Instruments</th>
</tr>
</thead>
</table>
| 1. The right to health | • Universal Declaration of Human Rights (UN General Assembly, 1948).  
• International Covenant on Civil and Political Rights (ICCPR) (UN General Assembly, 1966a).  
• Convention on the Rights of Persons with Disabilities (CRPD) (UN General Assembly, 2007).  
| Standards relating to the reform of onshore detention | |
| 2. Detention should not be arbitrary | • International Covenant on Civil and Political Rights (ICCPR) (UN General Assembly, 1966a).  
| 3. Detention should not be indefinite | • International Covenant on Civil and Political Rights (ICCPR) (UN General Assembly, 1966a).  
| 4. Detention should be used as a last resort | • Universal Declaration of Human Rights (UN General Assembly, 1948).  
• Convention relating to the Status of Refugees (UN General Assembly, 1951). |

35 Also see a range of reports and resolutions from the OHCHR Working Group on Arbitrary Detention (http://www.ohchr.org/EN/Issues/Detention/Pages/WGADIndex.aspx)
5. Vulnerable people should not be detained


6. Alternatives to detention should be implemented


7. Conditions of detention should comply with basic minimum human rights standards

- Universal Declaration of Human Rights (UN General Assembly, 1948).
- International Covenant on Civil and Political Rights (ICCPR) (UN General Assembly, 1966a).
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) (UN General Assembly, 1984).
- Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UN General Assembly, 2002).
| Standards relating to the reform of Australia’s regional policies and offshore detention | • Convention relating to the Status of Refugees (UN General Assembly, 1951).  
• Protocol against the Smuggling of Migrants by Land, Sea and Air (UN General Assembly, 2000c).  
|---|---|
| 8. Australia should reform its approach to irregular migration throughout the Asia-Pacific region | • Convention relating to the Status of Refugees (UN General Assembly, 1951).  
• Protocol against the Smuggling of Migrants by Land, Sea and Air (UN General Assembly, 2000c).  
| 9. Boat turn-backs of asylum seekers and refugees are not permitted | • Convention relating to the Status of Refugees (UN General Assembly, 1951).  
• Convention on the Law of the Sea (UN General Assembly, 1982).  
• International Convention for the Safety of Life at Sea (International Maritime Organization, 1974). |
| 10. Offshore detention centres should be closed and those detained there should be resettled in Australia | • Convention relating to the Status of Refugees (UN General Assembly, 1951).  
• International Covenant on Civil and Political Rights (ICCPR) (UN General Assembly, 1966a).  
• Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) (UN General Assembly, 1984).  
Before moving ahead, it is necessary to clarify that although the above sections have relied heavily on international treaties and instruments to justify standards for Australian immigration detention, it would be a mistake to see these standards as only a call for legal reform. As was discussed in Chapter 1, the Australian government has openly expressed disdain for human rights and international law and such top-down reform based upon these standards seems unlikely. This, however, is not the only way to shape and pursue human rights. Kennedy (2002) argues that the human rights movement has too often overestimated the power and value of international law. This view puts “too much faith in lawyers and procedures rather than challenging grossly unequal relations of power and voice through struggles to articulate more utopian visions” (Nash, 2015, p. 3). McCann and Lovell (2018, p. 156) similarly recognises that legal reform is often not enough to achieve longer lasting change. They suggest, on the contrary, that the law is often “a force for hegemonic preservation of status quo hierarchies”.

In moving away from such an approach and more practically, “if human rights are really to make a difference, if they are to become a language that can address injustices, it is clear that far more than law has to be changed” (Nash, 2015, p. 1). Social movements have an important role to play in this respect. There is an emerging literature that recognises this:

Rights are never effective simply because they are legal rights. Enjoying human rights in practice depends on how people use them—on what they claim, and how they make rights claims. This, in turn, depends on collective identity, on the pressure that people bring to bear because they have a “right to rights”—even where they do not have rights in law, or law is administered unjustly… Collective action is needed at every level if human rights are to make a real difference. Grassroots organizing is necessary if people are to be able to define human rights in ways that are appropriate to dealing with the injustices they face (Nash, 2015, p. 11).

Social movement theory is concerned with each of these questions: how grievances are framed; how people organise in the face of injustice and more broadly, the action they take in response

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36 Social movements and social movement theory will be introduced and discussed in detail in Chapters 5 and 6. Social movements can be defined as: “collective challenges, based on common purposes and social solidarities, in sustained interaction with elites, opponents, and authorities” (Tarrow, 2011, p. 9).
to injustice. It also goes hand in hand with pursuing and protecting human rights. So while human rights can be realised through more traditional top-down means such as legal reform, they should not be reduced to this, particularly in the case of Australian immigration detention. Human rights are given real force when people “define human rights in ways that are appropriate to help them overcome the obstacles they face, and… know how, and where, to address their grievances if the language of human rights is really to improve their lives” (Nash, 2015, p. 1). Additionally and also worth noting here is that action such as protest and non-violent civil disobedience are, in turn, protected by human rights and international law (Bennett, 2017).

2.6 Conclusions

If clinicians are to take action, clear standards are needed. Above, I have listed ten standards that promote systemic, social and political change consistent with human rights and international law. These standards ask nothing more of the Australian government than to uphold the commitments it has made. For clinicians and the broader healthcare community, the obligation to uphold and protect such human rights is clear. Finally, while this chapter relies heavily on human rights and international law, these standards should not be interpreted as a simple appeal for legal reform. Human rights give power to social movements and those seeking redress. I will return to this point in Chapters 5 and 6.
Chapter 3 Delivering Healthcare in Australian Immigration Detention: Challenges and Responses

3.1 Overview

In Chapter 1 I described Australia’s policy of mandatory immigration detention and the harm these policies create and perpetuate. In Chapter 2 I proposed a set of human rights standards to which Australia should be held. In Chapter 3 I discuss healthcare within Australian immigration detention and the problems faced in relation to its delivery. I evaluate the strengths and shortcomings of current responses to these problems.

I first outline the contractual and administrative arrangements for healthcare. Second, I provide evidence of the problems that arise in the delivery of healthcare. To do this I draw on some examples of testimony from clinicians and detained refugees and asylum seekers. Third, I review what the ethics literature has had to say about the delivery of healthcare in Australian immigration detention and how it has conceptualised these problems. Fourth, I discuss what professional healthcare bodies have said about Australian immigration detention, focusing on their position statements. Finally, I will describe the advocacy and protest actions taken by clinicians and professional bodies outside of detention.

My main argument in this chapter is that while current responses to the challenges of providing healthcare in immigration detention recognise the need for systemic, social and political reform, they are poorly equipped to bring it about. I will advance two related but distinct arguments as to why this is the case. First, current theoretical responses tend to individualise healthcare and the resolution of clinical and ethical dilemmas. Second, despite over two decades of protest action, there is no clear strategy to bring about broader reform and social change. In short, while there is wide recognition of the need for systemic, social and political reform, the concepts that are currently used to frame the ethical issues, and the practical guidance that is given to clinicians, fail to motivate change of this nature or produce clear strategies by which to achieve it.
3.2 Healthcare Arrangements in Australian Immigration Detention

After the wrongful detention of Cornelia Rau\textsuperscript{37} and Vivian Solon\textsuperscript{38} (Commonwealth Ombudsman, 2005; Palmer, 2005) the Detention Health Framework was established (Department of Immigration and Citizenship [DIAC], 2007). The purpose of the Detention Health Framework was to ensure that healthcare was open and accountable; accessible and consistent with Australia’s international obligations; comparable to a standard found in the Australian community, and that quality was ensured by independent accreditation\textsuperscript{39}.

The Australian government provides health services within detention through its contracted provider, IHMS, local hospitals and other contracted allied health professionals. IHMS has held the contract to deliver health services in immigration detention since 2007. Estimates of the value of the detention health contracts between 2009-2015 were approximately $1.6 billion dollars (Farrell, 2015b). The mission statement for IHMS declares:

IHMS will provide a level of healthcare to people in immigration detention consistent with that available to the wider Australian community, taking into account the diverse and potentially complex health needs of people in detention.

These services will be provided in a professional manner that is clinically appropriate, without any form of discrimination, with appropriate dignity, humanity, cultural and gender sensitivity, and respect for privacy and confidentiality (Australian Parliamentary Joint Select Committee on Australia’s Immigration Detention Network: Final Report, 2012, p. 82).

The arrangements for healthcare in offshore detention are similar to those found across the broader immigration detention network. IHMS provide services on site, while local hospitals and other allied health professionals are contracted to provide additional and specialist services. The Australian Parliamentary Library provides a broad overview of these arrangements:

\textsuperscript{37} Cornelia Rau was detained in immigration detention unlawfully for 10 months in 2004 and 2005. She had a history of mental health problems which were a significant factor that led to her detention.

\textsuperscript{38} Vivian Solon was illegally deported to the Philippines. She had sustained head injuries prior to being discovered by the immigration department and being deported.

\textsuperscript{39} As was outlined in Chapter 1 and as will be discussed throughout this chapter, the Australian government has failed in each of these things and such aims directly conflict with the greater aim of deterrence.
The provision of health care to asylum seekers on Nauru and Manus Island is governed by the ‘Heads of Agreement’ between the Commonwealth of Australia (represented by the Department of Immigration and Citizenship (DIAC)) and International Health and Medical Services (IHMS) (the contract). The contract was tabled in the Senate on 21 September 2012, with the payment schedule and financial details redacted. Despite this, some financial details are known, such as that IHMS will be paid $22 million for the provision of health care for six months from 14 December 2012. The contract was not published online and is only available from the Senate Table Office (de Boer, 2013, p. 1).

Promoting healthcare as open and accountable while limiting the availability of financial information and contracts is one of many inconsistencies that characterise official discourse around healthcare in the immigration detention setting. The main stated objectives of this contract are to provide healthcare services to asylum seekers on Nauru and Manus Island that are:

- ‘open, accountable and transparent’ and
- to a ‘standard and range of health care that is the best available in the circumstances, and utilising facilities and personnel on Nauru and Manus Island’ and ‘that as far as possible (but recognising any unavoidable limitations deriving from the circumstances of Manus Island and Nauru) are broadly comparable with health services available within the Australian community’ (de Boer, 2013, p. 2).

The qualification about the “circumstances” on Manus Island and Nauru provides a further way to dodge the other stated aims of providing healthcare to a standard comparable to that found in the Australian community. More broadly, these statements, objectives and contractual arrangements are clearly incompatible with the government’s more general approach to immigration detention which I outlined in Chapter 1. The realities facing clinicians in the delivery of healthcare are also dramatically different. To illustrate this point I will provide examples of testimony from clinicians who formerly worked within detention, including some reflections on my own experience. I will also introduce the testimony of detained asylum seekers and refugees.
3.3 Healthcare in Australian Immigration Detention: Testimony from Clinicians, Refugees and Asylum Seekers

There is now over 20 years of testimony from clinicians, refugees and asylum seekers who have worked and been detained in Australian immigration detention. This testimony raises a range of issues, but most generally highlights the compromised nature of healthcare and its drastic departure from the contractual arrangements discussed above. Below I will provide examples of testimonies that illustrate the kind of constraints placed on clinical practice in this setting.

3.3.1 What Does Clinician Testimony Say About the Provision of Healthcare in Australian Immigration Detention?

Dr Peter Young, Psychiatrist and former Medical Director of IHMS wrote and spoke extensively about his experiences in managing healthcare services across the detention network and his dealings with the immigration department. At the time he was the most senior figure who had worked in the system to condemn it. Here he discusses the impact of the government’s policy of deterrence, the impact this had on healthcare and why treatment was largely ineffective:

…you can’t mitigate the harm, because the system is designed to create a negative mental state. It’s designed to produce suffering. If you suffer, then it’s punishment. If you suffer, you’re more likely to agree to go back to where you came from. By reducing the suffering you’re reducing the functioning of the system and the system doesn’t want you to do that… Everybody knows that the harm is being caused and the system carries on. Everybody accepts that this is the policy and the policy cannot change. And everybody accepts that the only thing you can do is work within the parameters of the policy (Marr & Laughland, 2014, para. 24).

Dr David Isaacs, a paediatrics professor visited Nauru as a paediatric specialist. After he spent 5 days on Nauru seeing children in consultation he felt it important to highlight the appalling conditions. He describes what happened upon returning to Australia:
On our return to Australia, we were nervous about writing a media opinion piece, but our sense of outrage and our promise to the families trumped guilt at breaking our contract and fear of reprisal. A prominent human rights lawyer advised us it was legitimate to break a contract to reveal ‘iniquity’ and what we had witnessed was undoubtedly iniquitous. We decided to provide IHMS with a detailed report of suggested changes but also decided to publish an opinion piece and do subsequent media interviews. We met senior IHMS staff to discuss our report. They expressed disappointment we had gone to the media and felt betrayed. We said we thought IHMS tried hard in the camp and had done excellent work propping up Nauru health care services outside the camp (IHMS asked us to consult on some children at the Republic of Nauru Hospital), but we thought IHMS should protest more about conditions. The IHMS staff said their Government contract forbade them criticising Government policy and they preferred to work for change from within the system. The meeting ended with each of us acknowledging our respect for but disagreement with the others’ position (Isaacs, 2015c, p. 354).

Similar concerns were raised in the Christmas Island Medical Officers’ Letter of Concern (2013). This letter was written to IHMS by 15 doctors who had worked on Christmas Island. After IHMS failed to take action it was provided to The Guardian and made public (Laughland & Marr, 2013). While this letter raises a number of issues, underpinning almost all of them was the fact that patient care was compromised by IHMS’ relationship with the immigration department:

A conflict of interest exists, as a result of IHMS’ relationship with the Department of Immigration and Border Protection that can influence decisions regarding patient care. Decisions made by IHMS do not appear to have always been made in the best interest of patients. The shifting of responsibility between the DIBP and IHMS is likely to result in neither party acting appropriately in regards to patients (p. 5).

Furthermore these decisions place medical and nurse practitioners at great medico-legal risk, a fact that goes uncontested by management at staff meetings and yet has not been addressed. Management states that the Department of Immigration are accepting all responsibility. However, no third party has the power to absolve health practitioners of
their duty of care to patients and we must all adhere to AHPRAs code of conduct (p. 29).

A number of other clinicians have discussed how they delivered treatment and negotiated the day to day restrictions facing healthcare. Guy Coffey, a clinical psychologist and lawyer wrote about his experiences treating detained refugees and asylum seekers in the community, while working for Foundation House (formerly the Victorian Foundation for Survivors of Torture). He discusses a range of issues, present throughout his writing however is the tension in how he mediated the restrictions placed on his role:

Treatment recommendations may fail to consider patients’ broader interests and may be confined by policy goals within the detention environment. In other words, treatment recommendations may be formulated for “what is possible” given the current circumstances rather than what is in a patient’s best interests. In many cases, the action needed to assist in mental health treatment and recovery is it quite obvious, with the best option for most patients being that they are removed from the detention environment. The tensions though, in how far one takes recommending alternative arrangements, are obvious. Not to do so is to remain silent about a significant and perhaps determinative effect on the detainee’s prognosis. Some might argue that it is to collude with the convenient lie that extended detention can be psychologically benign. Conversely, making recommendations about services that are not available, or regularly insisting on the need for the detainee to be released, risks detracting from the measures that can be taken immediately. It is an approach that runs the risk of having recommendations dismissed as advocacy, of alienating the IDC management and the Department and therefore jeopardising the relationship between the IDC and the mental health service, and of leaving the IDC health staff feeling helpless (Coffey, 2006, p. 76).

Dr Nick Martin, a general practitioner who was a senior medical officer on Nauru discussed similar concerns about advocacy and the issues this raised about putting the interests of his patients first:

Activism was stamped on incredibly quickly. It was seen as the greatest crime to be considered an advocate; it was to invite a swift cancellation of your visa and non-
renewal of your contract. What was meant by ‘advocate’ was never explained. It seemed to me that our primary concern had to be the patient, and to push for the best appropriate treatment for them. If that was advocacy then surely it was what we did every day as doctors or nurses (N. Martin, 2018, para. 80).

Others have concluded that the delivery of healthcare within immigration detention is simply futile. Almost 15 years ago, a healthcare professional provided a testimony at the People’s Inquiry into Immigration Detention (ACHSSW, 2006, p. 44) which included the following statement:

You could have the Rolls Royce of mental health services in Baxter and I don’t think it would make a scrap of difference, because the environment is so toxic that you can’t treat anything meaningfully. I think that half a dozen of the most damaged people that I’ve ever seen are the adults that I’ve seen in Baxter and Woomera, both parents and single men. The thing is that it is all caused by being in detention. Provided you get them in time, you take these people out of detention and they’re not depressed any more. Of course the interpretation of that from DIMA is to say they’re putting it on, “Isn’t it convenient for them, the thing that was going to cure them from their depression is taking them out of detention.” The reason it’s going to cure them is because detention is a place that drives people mad and yeah, they want to get out of the place that is driving them mad.

Similarly, Harold Bilboe, a psychologist who formerly worked at Woomera detention centre was quoted during the first National Inquiry into Children in Detention:

No matter how much I worked with the clients, I couldn’t change the cause of the behaviour, the course of their stress, it’s like having a patient coming into the hospital with a nail through the hand and you are giving them pethidine injections for pain but you don’t remove the nail. That’s exactly what is happening in Woomera. You’ve got people down there with nails through their hands, we’re holding them, we’re not treating the cause. So, the trauma, the torture, the infection is growing. We are not treating it, we’re just containing it. Eventually when those people return to their homelands, if they don’t get temporary visas, they are going to carry that with them (HREOC, 2004, p. 423).
To this day, clinicians have continued to struggle with these issues. Reflecting on his time on Nauru, Dr Nick Martin questioned how he could deliver care in a system that was designed to harm people:

At what point do you throw your hands up, admit defeat, accept that the system can’t be beaten? The monolith of the government was behind this, inflexible, unswerving, shameless. What could I do? Send off yet another email? Hadn’t someone defined insanity as the art of doing the same thing over and over expecting a different response? Something like that. Christ, this was soul destroying. (N. Martin, 2018, para. 9).

My own experience of working as a clinician within immigration detention echoes several issues raise in the testimonies quoted above.

Healthcare in Australian immigration detention occupied an ambiguous space; it was never quite clear what your role was. I too was confronted with the question of how I could act in the best interests of my clients, and the answer was never clear. Orthodox mental health interventions were largely futile. As a Counsellor, I was often charged with running group programs. Common across all centres was a “relaxation” group. I questioned the value of such an intervention from day one and completely understood why some people couldn’t relax or didn’t want to relax. Whose interest was I serving? It would serve the interests of the immigration department and security contractors to keep the detainees as docile as possible. Surely those who were not relaxed, who were protesting, who were resisting had good reasons to do so. Surely those who attempted to escape and who were subsequently sent for counselling were behaving rationally. Most interventions, if done by the book were frustratingly ineffective. What might be labelled as “maladaptive” thoughts, feelings and behaviours in the psychological literature were completely functional in this environment.

Sometimes I was faced with obvious conflicts. For example, when, the immigration department asked for unnecessary assessments, or asked for interventions that would do nothing more than quell justified frustrations or protest. More often than not, however, these conflicts were subtle. There were expectations about my role, its limits and what I could and could not do, held by the immigration department and security contractors. These expectations were never made
explicit, but they were always pressing. This grey area however also presented opportunity to bend the rules. Doing so was a delicate dance, however. Picking my battles became an art.

What advocacy entailed was never quite clear. It was clear, however, that I could advocate only to the extent that the immigration department and security contractors allowed me to. This applied even to simple requests such as a change in accommodation or new clothing. I could be put in my place quickly if the immigration department or the security contractors chose to do so. While my “advocacy” was never punished, it almost always amounted to nothing. If the system was not trying to aggressively shut me down, requests or concerns that I raised would be lost in a faceless, non-accountable bureaucracy. The system carried on, oblivious to complaints and with little regard for the consequences of the ends it was pursuing.

To this day I ask myself what purpose I served while working in detention. I may not ever be able to fully answer this question, however there are things that I can say with some certainty. Delivering orthodox mental health care within detention is largely futile. Even if healthcare were to be improved, better resourced or delivered with greater oversight and accountability, it would make little difference as long as the Australian government maintains its policies of deterrence. Progress will not be seen in health and healthcare until there is major systemic reform.

3.3.2 What Does Refugee and Asylum Seeker Testimony Say About the Provision of Healthcare in Australian Immigration Detention?

In addition to the testimony above it is also important to consider the perspective of detained refugees and asylum seekers. While there is far less testimony, what has been published is often disturbing and highlights further problems in the delivery of healthcare. The two examples below comes from testimony provided by detainees to the Peoples Inquiry and subsequently reported by Briskman, Zion, and Loff (2010, p. 1099). They discuss two different instances of medical involvement in forced deportations:

I heard my name on the speaker, and I was escorted to meet the immigration officers. I said let me talk to my lawyer and they said no. They locked me in the isolation place. I was feeling very scared. Then I start to harm my hand. If my hand is injured they will take me to clinic. If they take me to clinic the other detainees will see me, they will ring
my lawyer. Then I found maybe 16, 17 officers around me. They hold my legs together and they bend the big belt and kicked my chin and bound my hands together. They stood over my body and the nurse have an injection and Valium tablets. I said I don’t want an injection. I don’t want tablets. They tried to do it maybe twenty minutes. I was very angry, screaming and they couldn’t. My muscle was very tight because I was frightened. And then they forced me.

The doctor entered the cell carrying an injection with four tablets, asking me to choose either the injection or the tablets. I refused both. The doctor offered the security officers to do their job and he and the officers laid me down on the floor and sit on my back, took my pants down. Then I accepted to receive the tablets. They didn’t work, so they force me to take a fifth tablet at the airport. They got me on the airplane with a wheelchair accompanied by a nurse, two companions and three other ACM officers, with three types of handcuffs and ties of leather, plastic and steel around my hand and belly that gathered my arms to my trunk.

Criticism has continued to this day. Behrooz Boochani, an Iranian refugee held on Manus Island for over 5 years has been vocal in his condemnation of Australia’s policies, including IHMS and the healthcare detainees receive:

There is no hope in Manus prison’s medical centre, which is run by IHMS. How many people have they treated successfully in these five years? Salim\(^{40}\) had nowhere else to turn; he returned to IHMS for help over and over again, at least to collect some pain relief. It was a like seeking asylum from your torturer… The IHMS has always been under the command of immigration. The institution is part of a predetermined political strategy which smothers sick refugees and tosses them into a horrific bureaucratic maze. They not only leave refugees untreated, they also aggravate the minor pains of healthy refugees and force them to return to the countries they fled (Boochani, 2018, para. 12-13).

The above testimony from clinicians, refugees and asylum seekers raises a range of issues, all of which impact the delivery of healthcare. The parlous conditions within detention, complicity

\(^{40}\) Salim was a Rohingya refugee who died in an apparent suicide on Manus Island.
with the harms created and perpetuated by these policies, the competing loyalties faced by clinicians, the near futility in the delivery of healthcare, the negotiation of advocacy and more broadly, disagreements about how to respond to these policies. Below I will discuss how the ethics literature has conceptualised these problems and the recommendations that come from this.

3.4 What Does the Ethics Literature Say About the Provision of Healthcare in Australian Immigration Detention?

The literature that examines the clinical and ethical issues relating to the provision of healthcare in Australian immigration detention does three things. First it includes empirical research into the provision of healthcare; second, it frames the issues raised in the delivery of healthcare as ethical problems, and third, to a lesser extent it provides guidance for clinicians and recommendations for the provision of healthcare. Chapters 1 and 3 have already outlined a range of issues related to the provision of healthcare. A number of papers included in the portfolio of published work also do this\textsuperscript{41,42,43}. The below discussion will therefore focus on how the literature has framed the issues discussed above as ethical problems and the guidance it provides for clinicians and healthcare more generally.

The ethics literature has given substantial consideration to explaining and conceptualising how clinicians negotiate their roles within detention. To do this, the literature has largely turned to the concept of dual loyalty (Briskman & Zion, 2014; Briskman et al., 2010; Essex, 2014; Sanggaran, Ferguson, & Haire, 2014; Zion, Briskman, & Loff, 2012). Dual loyalty describes circumstances where clinicians have to manage diverging interests between that of their patient and a third party. These conflicting obligations are not necessarily explicit; they can be implied or perceived, and the tension between loyalties can arise from “legal requirements, threats of professional or personal harm for non-compliance, the culture of the institution or society where the professional practices, or even from the professional’s own sense of duty to the state” (Physicians for Human Rights, 2002, para. 8). In Australian immigration detention, clinicians often find themselves caught between loyalty to those detained and their obligations to the

\textsuperscript{41}“Healthcare and clinical ethics in Australian offshore processing centres” (Essex, 2016b).
\textsuperscript{42}“Healthcare and complicity in Australian immigration detention” (Essex, 2016c).
\textsuperscript{43}“The ethics of discharging asylum seekers to harm: An example from Australia” (Essex & Isaacs, 2018)
immigration department, security contractors and IHMS, all of whom have differing and conflicting priorities.

The concept of complicity has also been used to a lesser extent to describe these conflicts (Essex, 2016c; Jansen, Tin, & Isaacs, 2018), in particular Lepora and Goodin’s (2013) framework of moral complicity. Lepora and Goodin (2013) suggest their model be used as a pragmatic tool to guide thinking, at the very least serving, “as a useful heuristic in reminding us what questions we need to ask in assessing acts of complicity morally and comparing them with alternative courses of action” (p. 103). Lepora and Goodin (2013) suggest a minimum threshold for complicity. In short the threshold proposed is one where agents may contribute knowingly in some way to wrongdoing, but not necessarily share the same intentions as the principal wrongdoer. This threshold requires (a) a voluntary contribution (b) knowledge (or culpable ignorance) of the contributory role played by their actions, and (c) knowledge (or culpable ignorance) of the primary wrongdoing to which they are contributing. Thus the degree to which an agent may be complicit is influenced by a number of factors, requiring a number of questions to be asked. Most importantly, how bad the principal wrongdoing was, whether the agent voluntarily and knowingly contributed to it, how much of a contribution was made and to what degree the agent shared in the principal wrongdoer’s purposes. This model has the potential to inform action within detention, something which will be discussed below. To this point however it has generally been applied to explore whether clinicians should engage with detention at all, or boycott it. This model is explained in greater detail and applied to consider the issue of a boycott, discussed in Chapter 4 and in one of the published articles included in my portfolio of published work.44

Drawing on these concepts, the ethics literature has also attempted to provide guidance for clinicians working within detention. For example, in responding to dual loyalty conflicts, the International Dual Loyalty Working Group proposed a comprehensive set of guidelines (Physicians for Human Rights, 2002). While these guidelines outline a range of circumstances where dual loyalty has been particularly problematic, they always call for clinicians to place their obligations to the patient above all other interests. If clinicians are to depart from this primary loyalty, it should first be sanctioned by “international standard-setting bodies competent to define the ethical obligations of a health professional” (Physicians for Human

44 “Healthcare and complicity in Australian immigration detention” (Essex, 2016c).
Rights, 2002, Guidelines section, para. 19) and where there is no explicit guidance, clinicians should not attempt to weigh the “interests of society or the state against the human rights of the individual” (Physicians for Human Rights, 2002, Guidelines section, para. 20).

Writing specifically about Australian immigration detention Briskman and Zion (2014) offer pragmatic advice as to how clinicians could respond to conflicts while working within detention. They call for clinicians to engage in both advocacy and subversion, calling on clinicians “to take political action that goes beyond kindness as either mild mannered or outraged dissidents” (p. 283). In this case they define subversion as “dispensing acts of kindness that may not be valued or even prohibited by the employing or subcontracting authority” (p. 279) and advocacy as “a means for people to take action arising from their witnessing” (p. 279). They thus move beyond calling for absolute loyalty to the patient and begin to outline in more practical terms, how clinicians should respond to the conflicts they face. These recommendations however don’t give further detail as to the practicalities of taking such action, or how to manage circumstances where advocacy or subversion may, on balance, do more harm than good, a concern that was raised by a number of clinicians quoted above (e.g., Coffey, 2006).

Lepora and Goodin’s (2013) framework provides a sophisticated way to begin to examine clinician’s contribution to wrongdoing, identifying (and in theory) avoiding the more harmful aspects for the system. In short, this framework helps clinicians deliberate as to whether they should be involved at all. This is structured in terms of whether they are contributing to more harm than doing good. Take the example of clinician involvement in deportations from the testimony discussed above. If asked to conduct an assessment for a detainee who is due to be deported, clinicians may opt to take up a position of advocacy, warning of the health and human rights consequences of a deportation. They may frame their assessment broadly and make strong recommendations against such action on health and human rights grounds. On the other hand, as suggested by the asylum seeker’s testimony cited above, clinicians may become actively involved in a deportation, using chemical restraint. Quite clearly one is more problematic than the other. Lepora and Goodin’s (2013) framework provides a means to identify such conflicts and, in theory, avoid them or take a more appropriate course of action. While Lepora and Goodin’s (2013) framework offers more in terms of guiding action than dual loyalty, minimising complicity with wrongdoing may not necessarily lead to better health or healthcare for those detained. Furthermore, the realities found within detention and restrictions
placed on clinicians may mean that minimising complicity in all circumstances is not possible. Additionally, these frameworks ask a complex series of questions which are difficult to apply both proactively and to each aspect of clinical practice.

In addition to describing the challenges in delivering healthcare, the ethics literature has also long made calls for reform (Zion, 2013). Throughout the literature a number statements can be found hinting that we move away from discussions of health and healthcare purely in terms of clinical ethics, instead focusing on a more activist, political stance. Briskman and Zion (2014, p. 284) suggest that “[f]or the ethical health worker, a focus on maintaining and incrementally improving the system is vexed and the aspiration must be the abolition of the detention system”. In aiming to achieve such change, Briskman, Zion, and Loff (2011) call for advocacy. Similarly Koutroulis (2003, p. 384) calls for clinicians to take up “a more active political stance”. Mares and Jureidini (2004, p. 526) ask, “at what point is advocacy at a social and political level justified, if not inevitable?”. Others have called for protest (Berger, 2016; Isaacs, 2015c).

3.5 What Do Professional Healthcare Bodies Say About the Provision of Healthcare in Australian Immigration Detention?

All major professional healthcare bodies have position statements or guidelines on Australian immigration detention. Each sets out to do at least one of two things. The first is to make explicit the position of the professional body on issues as they relate to refugee and asylum seekers in Australia, and the second is to provide clinical and ethical guidance as to the standard of care that should be provided. While these documents vary in scope and content, they have a number of common themes. All call for significant reform of Australian immigration detention. Some call for its abolition45 (RACP, 2015). Others call for an end to the detention of children (APS, 2011). Some call for the use of detention as a last resort only, and only for limited periods of time (AMA, 2015). Others base their calls for reform on existing human rights instruments (PHAA, 2015). All acknowledge the damage that Australian immigration detention does (AMA, 2015; APS, 2011; PHAA, 2015; RACP, 2015; RANZCP, 2016). The APS (2011) have notably framed their position statement more broadly than others, encouraging psychologists

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45 Some position statements are more consistent than others with the standards I outlined in Chapter 2. They all however call for major reform and for the protection of human rights.
to engage in broader social and political action along with promoting the rights, health and wellbeing of asylum seekers and refugees.

While the RACP (2015) refrains from providing specific guidance or recommendations, the AMA (2015) and RANZCP (2016) attempt to provide clinical and ethical guidance for clinicians and attempt to define a standard of care which should be provided. Similar to the International Dual Loyalty Working Group report discussed above (Physicians for Human Rights, 2002), they both seek to resolve dual loyalty conflicts by calling for clinicians to place the interests of the patient above all other obligations (AMA, 2015; RANZCP, 2016)\(^{46}\). They go on to outline a number of standards and guidelines in relation to healthcare. Consistent with the contractual and administrative arrangements discussed above, the standards and guidance outlined in these statements have either explicitly or implicitly been promoted as a standard equivalent to that found in the broader Australian community. For example, according to the AMA (2015, p. 3) position statement:

> Health and medical services in immigration detention centres should only be provided by organisations, in facilities accredited to Australian standards, 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.

This statement goes on to exhort clinicians to maintain a range of other standards, as would be expected to apply in community settings, such as confidentiality, reporting abuse or maltreatment, advocating for patient welfare and not participating in punishment or other activities that lead to harm.

While the RANZCP (2016) statement does not explicitly call for a standard of healthcare that is equivalent to that found in the broader Australian community, it puts forth a number of similar standards such as putting patients first, advocating for patients and maintaining

\(^{46}\) As do the Medical Board of Australia (2014) and the World Medical Association (2006).
confidentiality. The only professional body to question the utility of defining a standard of care and of providing advice for clinicians working within detention has been the RACP (2015, p. 17):

The RACP acknowledges the significant ethical issues related to providing care in detention, and the tension in defining a standard of care… While the Australian Department of Immigration and Border Protection has stated that “asylum seekers are provided with a standard of care broadly comparable to health services within the Australian community”, there are multiple constraints to providing healthcare in held detention, and people in detention are highly likely to have physical and mental health issues that require additional and specialised services. Further, health providers cannot address health issues caused by held detention while people remain in held detention.

The idea of equivalency can be found elsewhere. The Public Interest Advocacy Centre (2018, p. 4) for example calls “for health care to be provided to people in immigration detention in Australia at the same standard as is available in the Australian community: fair and humane treatment for people who are especially vulnerable, and consistent with our fundamental duty of care to those we detain”47. Similarly, Dudley (2016, p. 15) calls to transfer “healthcare from immigration to Federal and/or State health departments, with resources augmented to adequate standard, would strengthen clinical independence and quality, minimise healthcare’s being securitised and politicised, and uphold ethical codes”.

3.6 What Other Action Has Been Taken by Clinicians and Professional Bodies?

As I outlined in Chapter 1, Australian immigration detention has been one of the most contentious political issues in Australian politics for over two decades. The issues created by Australia’s policies cannot be reduced to clinical concerns alone nor can the actions from clinicians and professional healthcare bodies, with many taking action outside of detention, aimed at bringing about broader reform.

47 The report also states: “While PIAC does not support the approach of mandatory immigration detention and maintains grave concerns about the time for which people are detained, the focus of this report is on ensuring people in immigration detention have access to the medical care and treatment they need, at a standard consistent with the Australian community” (p. 8).
Clinicians have marched and protested Australia’s policies (Australian Associated Press, 2016a; Doherty, 2016a; Fiske, 2016a). Some have become whistle-blowers after working within the system (Doherty, 2016c; Isaacs, 2015c; Marr & Laughland, 2014; Sanggaran, Haire, & Zion, 2016). Clinicians have also worked more collaboratively with the government as members of IHAG until it was disbanded with little warning (Laughland, 2013).

While persistent opposition of Australian immigration detention has come from all corners of society, the most vocal protest has often been from those who are directly affected by government policy. For example, after the introduction of the Border Force Act (2015), over 40 “entrusted people” including doctors, nurses, social workers and teachers signed an open letter challenging the government to prosecute them (Farrell, 2015a)48. This was followed by a number of protests from clinicians around the country (Australian Associated Press, 2015b) and condemnation of the Act by the AMA and other health and medical bodies (Safi & Farrell, 2015). Many more clinicians took advantage of the protection offered by Parliamentary inquiries to continue to speak out, while others continued to write and speak out in defiance of the Act (Australian Parliamentary Select Committee, 2015; Briskman & Zion, 2014; Isaacs, 2015a; Sanggaran, 2015; Zwi & Mares, 2015).

Other action has been ad hoc. The case of Baby Asha provides one such example. In February 2016 a twelve-month-old asylum seeker, who came to be known as Baby Asha, was transferred from Nauru and hospitalized in Brisbane. After she received treatment, doctors refused to discharge Asha because she would be returned to Nauru. The media promoted this case and a protest mobilized outside of the hospital around the clock for 10 days, placing the government under increasing pressure to honour the doctors’ refusal to discharge (Hall et al., 2018). After negotiations with the government, Asha was discharged to community detention about ten days later. This case provides a good example of clinicians leveraging their relative power and this will be discussed again in Chapter 649.

48 As was discussed earlier, I was signatory to this letter. It is attached in the portfolio of published work.
49 An article in my portfolio of published work also explores the issues that this case raises for hospital discharges and what this means for other refugees and asylum seekers being treated in Australia. “The ethics of discharging asylum seekers to harm: An example from Australia” (Essex & Isaacs, 2018).
At the same time that doctors were refusing to discharge baby Asha, the AMA held a public forum to discuss the health of asylum seekers (Owler, 2016). The AMA has, to this point, been the only professional body to hold such a forum and publicly discuss these issues. Acknowledging the devastating impact that immigration detention has had on adults and that it amounted to a “state-sanctioned form of child abuse”, the AMA called for the immediate release of all children along with a moratorium on asylum seeker children being returned to immigration detention. Former President of the AMA, Brian Owler also called for the re-establishment of an independent body of experts to report on the welfare of asylum seekers and refugees and furthermore if satisfactory healthcare could not be provided, the governments “policies should be revisited”.

Protest outside of the healthcare community also amplified the publicity the case of Baby Asha received. The #LetThemStay movement focused on the case of Baby Asha, but also organised protests in 12 major cities over 12 days, calling for the government to stop the deportation (to Nauru and Manus Island) of 267 asylum seekers (Hall et al., 2018). This has not been the only action outside of the healthcare community. There have been a range of organisations, professionals and concerned citizens who have also driven efforts to bring about change, including multiple activities of the Asylum Seeker Resource Centre50, the Refugee Council of Australia, and the Refugee Action Coalition51. A growing number of detained asylum seekers and refugees have also spoken out publicly about their experiences (Boochani, 2016; M. Green, Dao, Neville, Affleck, & Merope, 2017; Robertson, 2017; The Wheeler Centre, 2017).

There are a number of other important examples of action outside of the healthcare community, for example, the No Business in Abuse52 campaign. This campaign placed pressure on companies who profit from immigration detention by divesting in them and encouraging others to do the same. This initiative aimed to end “abusive practices towards people seeking asylum” and mandatory immigration detention. Although it is difficult to determine the contribution of this campaign, the security company who managed offshore detention centres, Wilson Security, would not renew its contract (Doherty, 2016d) and the immigration department had taken steps to supress the names of detention contractors because of ongoing campaigns to boycott these companies (Farrell, 2017).

50 https://www.asrc.org.au
51 http://refugeeaction.org.au
52 https://nobusinessinabuse.org
3.7 The Strengths of Present Responses toward Health and Healthcare in Australian Immigration Detention

The preceding sections of this chapter have described a range of difficulties that constrain the provision of healthcare in Australian immigration detention settings. I have also described how these difficulties have come to light, the main ethical concepts that have been brought to bear, the guidance that has been given to clinicians, drawing on the testimony of clinicians and those who have been detained. I also outlined some of the political actions that have been taken outside of detention centres. I will now discuss the strengths of present responses, followed by a critique, evaluating whether present approaches sufficiently inform systemic, social and political change consistent with the standards outlined in Chapter 2.

Present responses toward health and healthcare have a number of strengths. First, the existing ethics literature has thoroughly documented the issues facing clinicians and how government policy deliberately undermines healthcare. It has gathered testimony from numerous sources and given insight as to why clinicians engaged and persevered working in immigration detention centres (Briskman et al., 2011). Dual loyalty has provided a straightforward way to conceptualise the issues and conflicts that undermine almost every aspect of healthcare within detention. Lepora & Goodin’s (2013) framework of complicity provides a means for clinicians to reflect on their roles and attempt to minimise their complicity with the more harmful elements of these policies.

This research has informed multiple inquiries and has provided a platform for advocacy outside of immigration detention. The restrictions placed on healthcare and immigration detention’s impact on health and wellbeing have been central to calls for reform for over two decades. Testimony from clinicians along with the impact of detention have also formed a central part of a number of legal challenges. For the same period of time, this research has continued to help keep these issues in the spotlight, both within and outside of academic circles, domestically and internationally.
Outside of detention, clinicians and professional bodies have led and bolstered the impact of protest. The case of Baby Asha and the protests after the introduction of the Border Force Act (2015) are two examples, which will be discussed again in greater detail in Chapter 6.

3.8 Do Present Responses Sufficiently Inform Systemic, Social and Political Change?

As was discussed above, I suggest that future action should aim to achieve systemic, social and political change consistent with the human rights standards as outlined in Chapter 2. The need for such change is based on the recognition that health is dependent on human rights first being upheld and that human rights cannot be upheld within Australian immigration detention (OHCHR & WHO, 2008). The literature and position statements discussed above are poorly positioned to pursue such change. Below I will advance two related but distinct arguments that explain why this is the case. First, current responses overly depoliticise and individualise health, healthcare and the resolution of dilemmas within immigration detention. Second, the concepts and guidance that can be found in the ethics literature and in professional position statements offer little strategy in relation to broader reform and social change.

3.8.1 Individualising Healthcare and the Resolution Ethical Dilemmas

The concepts and guidance found throughout the literature discussed above and in professional statements too often frame issues as being the responsibility of the individual clinician. While these criticisms are new in relation to Australian immigration detention, they fit within a larger literature that has critically examined professional codes of ethics (Sutrop, 2011). Practically, this isolates health and healthcare from the broader systemic and political forces that shape them, reducing issues of justice and rights to clinical dilemmas and resulting in clinicians being individually responsible for the resolution of irreconcilable dilemmas. If the systemic, social and political change outlined in Chapter 2 is to be achieved, this focus often obscures the source of these problems and how they could be addressed; failing to inform strategy for broader social and political change. This will be expanded upon below.

Both dual loyalty and Lepora & Goodin’s (2013) framework start with the assumption of conflict or wrongdoing. Both also focus on the clinicians’ response in either mediating or
resolving this conflict. While it is possible to have relatively benign dual loyalty conflicts this is not the case in Australian immigration detention. What should be issues of rights and justice are framed as clinical dilemmas, for which clinicians are responsible. While discussions about healthcare and ethical conduct within detention centres should continue, we should be under no illusions about the limitations of such action. These concepts say little about how to truly address the sources of these conflicts or the initial wrongdoing that creates them.

Professional bodies have fallen into a similar trap. The AMA (2015) position statement for example recognises that reform is needed, and calls for a solution to “prolonged, indeterminate detention… as a matter of urgency” (para. 18). It recognises that “immigration detention centres violates basic human rights and contributes adversely to their [i.e. detainees’] health” (para. 18) while at the same time calling for clinicians to “at all times insist that the rights of their patients be respected and not allow lower standards of care to be provided” (para. 11). This puts clinicians in an impossible position. Human rights cannot be protected within Australian immigration detention centres. The RANZCP (2016) guidance raises similar issues. The limitations facing clinicians however are more squarely acknowledged, with the RANZCP (2016, para. 2) stating that they are “concerned that the capacity of psychiatrists to provide high quality mental healthcare and to practice ethically and effectively in detention centres and alternative places of detention is currently limited”.

This approach has other shortcomings, beyond failing to inform strategy for broader social and political change. It also leaves a number of questions unanswered regarding clinical and ethical decision making for clinicians working within detention. There remains a stark contrast between the concepts and guidance discussed above and the testimony of clinicians. Sanggaran and Zion (2015, p. 561) have described this as “the chasm between acceptable standards of medical care and what we know is being practised in immigration detention”. Some of these issues are discussed in an article included in my portfolio of published work. In this article I explore whether an equivalent standard of healthcare, similar to that put forth by professional bodies, can be achieved within Australian immigration detention. I argue that not only is such a standard failing to be achieved, but that comparing health and healthcare in the Australian

53 The AMA (2015, para. 13) position statement also calls for: “Professional medical organisations should develop a set of ethical guidelines to support medical practitioners working with asylum seekers and refugees in whatever context”. This has yet to happen and again seems to be passing responsibility to engage with the very difficult issues healthcare within Australian immigration detention raises.

54 “A community standard: Equivalency of healthcare in Australian immigration detention” (Essex, 2016a)
community to health and healthcare in Australian immigration detention makes little sense. I conclude that “[a]s long as Australian immigration detention is geared to promote suffering as a means of deterrence, there looks to be few ways to address these issues in any capacity, let alone achieve health and healthcare that are equivalent to that found in the broader Australian community” (Essex, 2016a, p. 979). This does not mean that standards in relation to healthcare should be abandoned, however defining them is far more difficult than simply falling back on the fiction of a standard equivalent to the broader Australian community. Other questions remain in addition to what was discussed in this article. If clinicians are acting in their patient’s best interests, as they would in the broader Australian community, does this mean they should advocate for their release or simply pursue care as usual? What does upholding a patient’s dignity mean when their rights are being intentionally violated? What is autonomy for those locked up indefinitely? Dignity could mean protest. Autonomy could mean insisting on healthcare outside of detention. Over 80% of paediatricians consider immigration detention to be a form of child abuse (Corbett, Gunasekera, Maycock, & Isaacs, 2014). Clearly providing well-resourced paediatric care is not enough. Broader reform is needed.

In summary, while existing concepts and guidance might be used to argue for the need for systemic, social and political change, their framing as issues being the responsibility of the individual clinician have ensured they say little about how such change could be achieved. This is not to say that the literature and professional bodies haven’t recognised the need for reform or to the need to take more assertive social and political action. This will be discussed below.

3.8.2 Limited Strategy for Social and Political Change

While the need for systemic social and political change has also been recognised, beyond the calls for change in the position statements and ethics literature discussed above, little has been said about strategy or how clinicians should contribute to such change. This has resulted in at least two major issues when examining the involvement of clinicians and their professional bodies in social and political change. First, action has been led from the “bottom-up”, that is, clinicians have often taken it upon themselves to protest, with the majority of action being improvised and piecemeal. This is not a problem in itself and action has at times been relatively

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55 As was discussed above, the RACP (2015) is the only professional body to acknowledge the difficulties in defining a standard of care and refrains from providing advice.
impactful, however without an overarching strategy past action has likely failed to recognise and capitalise on many opportunities.

Second, action has often fallen back on familiar repertoires such as advocacy, research and strongly worded statements, the majority of which assumes the government is rational and open to evidence and change. Some have expressed their frustrations with this. Sanggaran and Zion (2015, p. 561) ask, “[w]hat more could be done to make us pay attention to the need to move beyond the multiple peak body position statements?”. Berger (2016, p. 1) recognises that “evidence of ill treatment alone is not going to change things and that in this topsy-turvy world it may even make things worse”. Despite these more recent frustrations however, the discussion about what to do and what action could be effective has evolved little beyond McNeill’s (2003, p. 501) recognition of this over 15 years earlier:

The acceptable public health strategies of disseminating information and advocacy may not be enough. Something more is needed. Not violence – although the Australian Government has resorted to it – for the obvious reason that in resorting to violence we become the perpetrators of harm ourselves. Reasoned advocacy may not be sufficient. It is time for a more passionate response... These actions may go beyond dissemination of information and reasoned advocacy, and could include any number of political activities including: participating in demonstrations, direct lobbying of government members and political parties, and withdrawal of services.

In addition to this, action over the last two decades has evidently not achieved sustainable, long term reform. While improvised grassroots action should be encouraged, existing efforts would be bolstered by the introduction of strategy and reflection on other movements who have also fought for recognition and justice. This will be discussed in greater detail in Chapters 5 and 6.

3.9 Conclusions

Australian immigration detention poses a range of practical and ethical challenges to healthcare. It operates outside of normal legal protections, in an environment where normal safeguards do not apply and human rights are deliberately violated. The issues this creates have been well documented and are longstanding. For these reasons it is somewhat surprising that
there has been relatively little self-reflection and critique on how healthcare and reform have been approached. After two decades and little progress, there has long been a need to reconsider these issues. Above I argued that while current responses recognise the need for systemic, social and political reform, they are poorly equipped to bring it about for two reasons: current theoretical responses tend to individualise healthcare and the resolution of clinical and ethical dilemmas and there has been no clear strategy to bring about broader reform and social change. These issues raise another question; whether clinicians should work within detention centres at all. In Chapter 4 I will discuss the question of a boycott before proposing a new approach toward health and healthcare in Chapter 5.
Chapter 4  Should Clinicians Boycott Immigration Detention Centres?

4.1 Overview

Given the realities of providing healthcare within immigration detention, should clinicians boycott? There has been little consensus and discussions have failed to deal with the ethical and practical issues that a boycott raises.

I will draw on Selemogo’s (2013) criteria related to medical boycotts and Lepora and Goodin’s (2013) framework of complicity to weigh whether a boycott is both ethically justified and feasible. Taking into account the costs and benefits of current engagement and the potential impact of a boycott—and in particular the potential it has to further harm those detained—I conclude that under current circumstances a boycott cannot be justified. Even if this line of argument is not accepted, a boycott appears unlikely in the foreseeable future without a consensus amongst the healthcare community. Future action should plan accordingly.

4.2 Boycotting Australian Immigration Detention

4.2.1 A Background to Boycotting Australian Immigration Detention

Clinical ethics provides scope to boycott. This is addressed by the World Medical Association (2012, para. 7-8):

Whenever possible, physicians should press for reforms through non-violent public demonstrations, lobbying and publicity or informational campaigns or negotiation or mediation… If involved in collective action, NMAs [National Medical Associations] should act to minimize the harm to the public and ensure that essential and emergency health services, and the continuity of care, are provided throughout a strike56.

56 The differences and similarities between a boycott and strike will be discussed below.
A boycott was initially raised in the literature by Sanggaran et al. (2014, p. 378) who called for the discussion of “the potential role of a professional boycott to motivate change”. Against a backdrop of increasingly alarming reports from within detention centres and an increasingly secretive and combative approach taken by the government, including the introduction of the Border Force Act (2015), Isaacs (2015b, p. 2) called a boycott “the only ethical option available”.

The only major healthcare body to publicly discuss a boycott has been the AMA. As was mentioned above in Chapter 3, during its forum in Sydney (Owler, 2016) called for the immediate release of all children along with a moratorium on asylum seeker children being returned to immigration detention. The AMA also called for the re-establishment of an independent body of experts to report on the welfare of asylum seekers and refugees and furthermore if the satisfactory healthcare could not be provided, the governments “policies should be revisited”. The AMA called for no further action including the possibility of collective political action. The reasons against a boycott were specifically addressed. The AMA asserted that by working in immigration detention clinicians were not complicit in wrongdoing, rather they were simply placing patients first and that if any change should come, it should be through the weight of public opinion. This oversimplification denies the realities of delivering healthcare in immigration detention and is at odds with the testimony of clinicians and well documented issues with healthcare discussed in previous chapters. The AMA also fails to take any responsibility in making such a decision by calling for “the weight of public opinion” to decide.

Others have engaged with the issues in more depth. In an article published shortly after the AMA forum, Sanggaran (2016), a doctor who formerly worked in detention, called for a boycott. He cites the contradictions of working within immigration detention and the AMA Code of Ethics (2016) and discusses both the compromised nature of healthcare and how clinicians have enabled human rights abuses in the detention context. He also directly addresses a number of arguments against a boycott including the impact a boycott would have on those detained, that public opinion must shift first, that Australian staff will be replaced by overseas staff and the need for consensus amongst professionals to boycott.
A number of weeks later Berger and Miles (2016) debated this issue. Arguing in favour of a boycott, Berger outlined the harm that immigration detention does and the restrictions on providing healthcare in these environments, including clinicians being co-opted by the system. He went on to say that clinicians should continue to offer their services, but only if “tortuous” conditions end, if clinicians have greater independence and transparency increases. Miles who disagrees with the use of the term “boycott” states that, “these egregious circumstances do not justify a boycott that would further isolate internees from adequate care…The AMA should buttress its commendable reports and ethics codes with more aggressive action. It should help frontline clinicians to transmit reports, pictures, and data through encrypted and anonymous web channels to international human rights organisations” (p. 2). Miles goes on to call for a legal defence fund to be set up for any clinicians prosecuted under the Border Force Act (2015) and that if a boycott were to be considered, “they [the healthcare community] should target the government rather than the detainees. Action could include withdrawing from working in staff clinics within government ministries (such patients can go to the regular healthcare system). It could include pausing consultative roles with government ministries, suspending the submission of government forms (birth and death certificates or medical clearance for military service), and so on” (p.2).

To this point, arguments both for and against a boycott remain underdeveloped. While some key questions have been asked, many points have been overlooked or deserve greater attention. Below I will expand on existing arguments while introducing a number of new points to the discussion.

4.2.2 A Boycott, Strike or Something Else?

In discussions about Australian immigration detention, a boycott has meant the removal of all clinical staff from detention. In this respect, Miles (2016) is correct in asserting that it could also be labelled a strike. A boycott could take a number of forms, however, and each changes the ethical and practical dimensions of the problem. The motivation behind a boycott is particularly important to consider. My argument below centres on a largely consequentialist justification for my position, that is, a boycott is treated as a means of achieving a desired end. If a deontological approach were taken however, different conclusions could be reached. For example, what if the motivation to boycott were instead to ensure that clinicians were not complicit in wrongdoing. This individualistic and broadly deontological motive does not
necessarily change the consequentialist reasons for boycotting, or not. In this sense, from a deontological perspective, for clinicians who do not want to be complicit in wrongdoing their own (personal) boycott might still be justified.

More practically, there is also a need for future discussion to be more precise in relation to who boycotts, how it is conducted and what the boycott is demanding. Should a boycott involve all clinicians working within immigration detention centres? Or should emergency (or essential) staff remain? Should there be rolling boycotts? Closely related to this are the demands attached to a boycott (discussed below) along with whether a boycott should be carried out indefinitely until these demands are met. Each course of action will raise different issues. For example, if some staff were to remain, what safeguards would be put in place that protect them and the people they care for? Would this go some of the way to addressing this issues discussed in relation to proportionality below? Beyond staffing, a boycott could take a number of other forms. For example, companies who profit from immigration detention could be boycotted, similar to the No Business in Abuse campaign discussed in Chapter 3. Medical supply companies could boycott IHMS. I will discuss other options for a potential boycott in Chapter 7. The remainder of this chapter will assume that a boycott means the withdrawal of all healthcare staff from all immigration detention centres.

Consideration also needs to be given to the conditions under which people are detained, with centres varying significantly across time and place. For example, the conditions in onshore APODs are generally preferable to those found in offshore centres. Disturbing reports from Woomera IDC (open from 1999-2003) and Baxter IDC (open from 2002-2007) also stand in contrast to other centres. While generalisations across centres can still be made, it is important that these differences are not overlooked if a boycott is to be justified, even in part on the conditions in which people are detained. Current discussions have overlooked these differences.

4.2.3 Key Questions Related to a Boycott

Drawing on just war criteria, Selemogo (2013) highlights a number of key issues that should be considered before withdrawing services in a healthcare context. These criteria act to some degree as a safeguard, asking those who are contemplating a boycott (or strike to use Selemogo’s terms) to consider a series of important questions. These include, 1) whether the
cause for boycotting is just; 2) whether a boycott is a last resort and other non-disruptive alternatives have been considered; 3) whether the declaration of a boycott action projects the view of the majority of the profession; 4) whether in the current circumstances, the boycott is likely to achieve its objectives and finally, 5) how to ensure patients are not disproportionately harmed by the boycott. Selemogo (2013) also suggests that all of this is communicated to those impacted by the boycott beforehand.

Would a boycott of Australian immigration detention meet any of these criteria? First, there should be little doubt that the cause of a boycott is just, for Selemogo (2013, p. 36) this relates to intent, namely that a boycott is motivated to “defend (or stop grave violations of) the right to the health of individuals or communities”. For those who have called for a boycott there should be little doubt about their motivation. They have little to gain personally, if anything exposing themselves to significant risk by calling for such action.

More doubt hangs over other questions, however. Have all alternatives to a boycott been considered? As was discussed above, clinicians and professional bodies have been involved in advocacy, research, whistleblowing, protest and disruption for close to 25 years. While it seems fair to say ‘yes’, the question itself is misleading. Pursuing social change, particularly through adversarial means, often involves a broad repertoire of interrelated actions, the effectiveness of which change over time because of a number of dynamic, relational factors. Those seeking social change do not simply cycle through action until something is found that has an impact. Thus a boycott should not be seen as a last resort but as one option in a broader repertoire of potential action. This will be expanded upon in Chapter 6 when considering how social movement theory should inform future action.

Selemogo’s (2013) third criterion relates to whether a boycott has the support of the majority of the profession. Selemogo (2013) suggests that clinicians should have the support of a central body, such as a union or professional body, arguing that the support of professional bodies creates an added “safeguard and legitimacy” and guards against “militant” clinicians. A boycott has not yet received support from any professional bodies or agencies that represent clinicians. To this point the AMA is the only professional body to have discussed this issue and state their position publicly (Owler, 2016). Practically, a boycott will only be effective if the entire healthcare community agree to participate. This raises the further question of whether such action should or could be enforced. If a boycott was not enforced it would risk being ineffective,
as it is unlikely all clinicians would participate. If a boycott were enforced a range of further questions would be raised. Who could enforce it and how might this be done? Another possibility is that the government would employ foreign staff, which would be relatively easy to do in offshore centres. On the other hand, replacing Australian staff with foreign staff may also lend further support to a boycott, in that foreign staff would provide some level of care and thus provide a degree of assurance that this action will not disproportionately harm those detained. A similar argument could be made if emergency staff were left in place during a boycott. These possibilities raise the issues of proportionality, something which will be discussed below.

Would a boycott achieve its objectives? Before considering whether the objectives of a boycott are likely to be met, objectives need to be set. This in itself creates problems. Chapter 2 proposed a range of objectives consistent with international human rights instruments. If it is accepted that these are the standards Australia should be held to, should those boycotting accept compromise? For example, suppose the government offers substantial improvements to healthcare (e.g., greater oversight, transparency and adequate facilities) but refuses to change other policies, such as the closure of offshore centres. Should such a compromise be accepted? Finally, and related to this, a boycott may not directly advance its originally planned objectives; it may even have unintended consequences.

Whether a boycott would harm those detained should weigh heavily in any decision making. Arguing for a boycott Sanggaran (2016, para. 15) contends that, “[o]ne must consider the patients’ best interests. Does it in fact serve a patient’s best interests to provide the documented substandard care? Or is the patient better served by the withdrawal of medical services so that the pretence of care is not maintained?” This is not elaborated upon, however Sanggaran (2016) appears to imply that no care is better than substandard care. While I agree that the care provided within detention is substandard and largely futile as I argued in Chapter 3, I don’t believe it is completely futile; there is still capacity for clinicians to do some good. Without healthcare staff, there would be no support to deal with those who were acutely unwell. Furthermore, one of the most impactful things clinicians have done is report their experiences of working in detention. A large portion of what we know about healthcare within immigration

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57 Even if these standards are not accepted and a boycott demands more modest change the same issues are likely to remain.
detention has come from clinicians themselves. If staff were to boycott far less would be known about the ongoing abuses in centres and the issues this creates for healthcare. Berger and Miles (2016) also fail to discuss proportionality in any depth. Other authors have turned to Lepora and Goodin’s (2013) framework of complicity to begin to analyse these issues. Weighing the costs and benefits of current engagement, while also identifying a number of ways clinicians may be able to reduce their contribution to wrongdoing while working within immigration detention, Jansen et al. (2018, p. 141) conclude that, on balance, clinicians should continue to work in detention:

Working in immigration detention centres puts doctors in an ethically tenuous position, but, on balance, it is right for doctors to continue to provide medical care to people seeking asylum. In order to do so without being unjustifiably complicit in torture, doctors must practise in an uncompromisingly humanistic way, should publicly speak out about the harms being perpetrated and should be constantly mindful of the potential for corruption.

Closely related to each of these criterion is an important point which has too often been overlooked or conflated\(^{58}\). While we can assess the current costs and benefits of engagement with Australian immigration detention, we can only approximate the impact of a boycott. Doubt hangs over what steps the government could take in response to such action, the compromises that might need to be made from the healthcare community, how the general public may perceive such action and most importantly, the harm that could be done to those detained. This might already be obvious from the many rhetorical questions that remain unanswered in this chapter. Future action therefore needs to weigh the costs and benefits of continuing to practice immigration detention settings against the potential costs and benefits of boycotting.

4.3 Should Clinicians Boycott?

A boycott is appealing when weighing the current costs and benefits of continuing to practice immigration detention settings. We know healthcare is compromised and more orthodox interventions largely futile. Adding further weight to this is the fact the government has been

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\(^{58}\) I have also done this in my article “Healthcare and Complicity in Australian Immigration Detention” (Essex, 2016c) Please see my statement on my portfolio of published articles.
largely hostile to evidence and advocacy; unwilling to entertain alternative policy for over two decades. However the same cannot be said about the potential costs and benefits of a boycott. If a boycott were to occur the potential harm of a boycott provides reason to be, at a minimum, cautious. Some assumptions can be made with more certainty than others. Swift and significant policy change is unlikely, this could result in a protracted situation where there was limited or no healthcare within detention centres. Conditions would worsen without the involvement of Australian clinicians. In saying this, the Australian government could employ clinicians from other countries to address staffing shortages while continuing to pursue its present policy, as will be discussed below, this could weigh in favour or against a boycott. The well documented vulnerabilities of those detained only provide further reason for caution. Taking all of this into account, a boycott becomes difficult to justify.

Regardless of this and even if this line of argument is not accepted, a boycott appears unlikely into the foreseeable future. No professional bodies have voiced their support and only the AMA have publicly engaged with this issue. Even with professional bodies any such action would require near consensus among the healthcare community. Thus, clinicians are likely to remain working within immigration detention into the foreseeable future. Any future response should therefore plan accordingly.

This doesn’t mean that we should accept the status quo. A case was already made against current responses toward healthcare in Chapter 3. This also is not to say that the option of a boycott should be completely discarded. A boycott may become more or less appealing depending on a number of factors. Changing circumstances within immigration detention centres would change the ethical and practical considerations in boycotting. If the government were to implement increasingly harsh measures, a boycott may be both more and less appealing. The same is true if conditions were to improve. For example while on face value it may be appealing to boycott if conditions in detention became increasingly punitive, these conditions could also leave detainees more vulnerable. Similarly, increasingly secretive policy could also make a boycott more appealing, on the other hand it may compel clinicians to stay to witness and report on subsequent abuse. For these reasons, it is important that discussions continue in relation to a boycott. While this chapter has cautioned against a boycott, I have not always held this opinion. An article included in the portfolio of published work also deals with
the issue of a boycott, and more specifically, proportionality. In this article I conclude that “current engagement with Australian immigration detention cannot be justified on balance” (Essex, 2016c, p. 145). My statement on my portfolio and a further article, which is an adaptation of this chapter both provide reasons as to why I have changed my position.

4.4 Conclusions

The question of a boycott and the debates that followed revitalised a somewhat stagnant literature by prompting discussion/debate about the action clinicians should take in response to Australian immigration detention. This discussion also began to shift the focus of the debate from the clinical to the political, asking what could happen if clinicians were to act collectively. I will discuss the roles of clinicians and professional bodies in social and political change in the remainder of this thesis. While difficult to justify under present circumstances, a boycott should remain amongst a potential repertoire of action; it should be seen as one option amongst many and as part of a larger strategy. Social change has not come from boycotting alone. Such an approach will require engagement with broader literatures and embracing action which sits outside the traditional clinical repertoire.

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59 “Healthcare and complicity in Australian immigration detention” (Essex, 2016c)
60 “Should clinicians boycott Australian immigration detention?” (Essex, 2019)
Chapter 5  Reconceptualising Health, Healthcare and the Roles of Clinicians and Professional Bodies

5.1 Overview

A fundamental shift is needed in how clinicians and professional healthcare bodies engage with Australian immigration detention, both in providing healthcare and in pursuing reform. In Chapter 3 I evaluated the delivery of healthcare in Australian immigration detention and critiqued some of the shortcomings of present responses. This chapter will address these shortcomings and chart a way forward. I will call for two shifts. The first is a greater politicisation of health and healthcare in relation to Australian immigration detention. This means a greater acknowledgement of the trade-offs that come with working within the system, but more importantly (and in acknowledging these limitations) a greater focus on justice and rights rather than the day to day clinical issues. The second shift is closely related to the first, and entails expanding the roles that clinicians and professional bodies have outside of the detention setting. This entails engaging with a broader literature on social change and embracing social and political action as central to their roles. In taking such an approach and expanding the existing theoretical repertoire I will first begin to sketch what this means more generally and then introduce the concepts of the humanitarian border and solidarity as well as the literatures on public health ethics and social movements. I will argue that these theories supplement existing theories and that they also provide a far better platform to begin to discuss systemic, social and political change in line with the standards proposed in Chapter 2. Thus, the theories and concepts critiqued in Chapter 3 should not be dismissed completely, instead they should be seen as forming part of a broader repertoire that should be used to both explain these issues and respond to them.

61 I will discuss why clinicians and professional bodies should do so in Chapter 6.
In Chapter 3 I argued that present approaches toward health and healthcare within Australian immigration detention are poorly equipped to bring about systemic, social and political change consistent with the standards outlined in Chapter 2. More specifically, responses tend to individualise healthcare and the resolution of clinical and ethical dilemmas. Furthermore, despite over two decades of practical protest action, there is no clear strategy to bring about broader reform and social change. Below I will begin to address these shortcomings, by calling for two shifts that focus on politicising and expanding the roles of clinicians and professional bodies.

What could political action look like both within and outside of Australian immigration detention? First, within Australian immigration detention, this will require a greater acknowledgement of the trade-offs and limitations in the delivery of healthcare, but also a greater focus on justice and rights over day to day clinical issues. This means putting what Schrecker and Bambra (2015) call the “sticking plasters” often found in the clinical repertoire into context. Examples of this include cognitive behaviour therapy for those who are overwhelmed because of their circumstances, or anger management for those who have a legitimate right to protest or more generally providing treatment, to at best, to maintain people to face further detention. This also means greater engagement with more fundamental questions, which were discussed in Chapter 3, such as what autonomy and dignity mean within Australian immigration detention, as well as how to uphold and protect these. Such an approach will also require a shift away from the focus on “individual agents and their moral integrity” to the “institutional context of their actions and their effects” (Dasandi & Erez, 2017, p. 6) and thus better accounting for “the specific social and institutional contexts, and the behaviour of other actors given these contexts” (Dasandi & Erez, 2017, p. 5). While such an approach may not necessarily lead to a resolution of the dilemmas faced within immigration detention, it puts any future response in a better position to inform systemic change and address the many well documented issues related to health and healthcare. Working within immigration detention

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62 As I will outlined below in this chapter when discussing the humanitarian border, healthcare should not only be seen within its “institutional context” of detention centres themselves, but amongst the broader policy context of immigration detention.
alone however is unlikely to lead to redress or address the standards outlined in Chapter 2, thus this approach also naturally shifts the focus of action to broader systemic, social and political reform.

This leads to the second related point, that clinicians and professional bodies should expand their roles, engaging with a broader literature on social change and embracing social and political action as central to their roles. While a starting point is somewhat difficult to identify, broadly, taking such an approach “requires a willingness to bring together a… perspective reared on causality, evidence, determinants, and interventions with a lens that deals with the nature of power, systems, wicked problems, uncertainty, and complexity” (Kickbusch, 2015, p. 2), while recognising that change in this context “requires political awareness and political struggle” (Bambra, Fox, & Scott-Samuel, 2005, p. 188). Such an approach goes beyond calls to action or identifying the need for reform in position statements; it will require sophistication and a greater understanding of how social and political change occurs. As I argued in Chapter 3, while the need for systemic and political reform has been long recognised, beyond calls for advocacy, protest or ongoing political engagement, little more has been said. Furthermore the discussion in regards to what should be done has evolved little beyond McNeill’s (2003) recognition of this fact over 15 years earlier. This issue is not isolated to the literature that examines Australian immigration detention. It is also common throughout the public health literature, as Greer et al. (2017, p. 40) argues:

Numerous ‘calls to action’ exist in the literature, alongside calls for ‘political will’. Still more articles identify problems but offer at most policy recommendations that go unheard beyond our paywalls, as if the politicians were to blame for not reading our journals and inferring what to do. This reveals a weak understanding of politics. Public health professionals would not, for example, call for ‘individual will’ as a solution to obesity. Nor should we call for political will as a solution to policy problems.

Recognising that calls to action had achieved little and that advocacy and reasoned argument had done little to sway a recalcitrant government, more recently Berger (2016, p. 1) made an impassioned call for protest:

Advocates of humane treatment for asylum seekers are left once more scratching their heads and wondering how much more evidence is needed before anything will change?
As doctors, we are now conditioned to believe that evidence is prime and that progress occurs as a result of refining the evidence base. Even in medicine, however, this is not a smooth process, and in the parallel universe of politics it is even less so. In fact, in our increasingly “post-factual” age, these rules are often reversed…Doctors in Australia must now make a mass public statement of their revulsion at the bipartisan support of our politicians for a policy of cruelty and oppression towards the innocent: “We are your doctors. We live our professional lives by a code of ethics over 2000 years in development. We say that what is happening in Australia is wrong and debases us all. We demand that this ill treatment cease.”…I say to all Australian doctors—young, old, the political, and the apolitical—that not just our ethical credibility as a profession but our shared humanity depends on this action. Evidence based argument has failed. Your physical bodies are now needed, in their thousands, to proclaim a message of common decency (p. 1).

In further advancing the question of what clinicians and professional healthcare bodies should do, it is first worth considering a distinction drawn by Raphael (2009) who suggests two possible avenues for action: “professionally-oriented rational or knowledge-based approaches” and “social and political movement-based materialist or political economy-oriented approaches” (p. 145). Professionally-oriented approaches entail “research, knowledge dissemination, and public policy advocacy with the aim of convincing policymakers to enact health-supporting public policy” (p. 160) and assume that governments will be receptive to ideas and evidence. A movement-based approach recognizes powerful interests that may be resistant to such ideas and “suggests the need for developing strong social and political movements with the aim of forcing policymakers to enact health-supporting public policy” (p. 160). Raphael (2009) argues that a movement-based approach is more effective when attempting to shift “liberal political economies” (p. 161). In further shaping a response Greer et al. (2017) suggests that consideration should be given to the range of contextual factors that shape the political landscape, including historical and social factors and restrictions and opportunities related to health. On this point, a number of realities discussed in Chapters 1 and 3 are worth re-stating. First, the government has made it clear that those offshore would not be resettled in Australia. Second, there is bipartisan support for these policies. And third,

63 The definition of a movement-based approach will be expanded upon below and discussed throughout Chapter 6.
successive government have often been irresponsible, and even combative, towards advocacy, reason and research. The government has shut down any collaborative efforts with clinicians and professional bodies (Laughland, 2013) and had even attempted to shut clinicians out of the debate with the introduction of the Border Force Act (2015). Change will not be led by major political parties and more orthodox or familiar repertoires of action, such as research and advocacy, are likely to have little impact. Calling for policies to be revisited as the AMA have (Owler, 2016) will continue to have little impact. While most would recognise these limitations, they are often overlooked when considering what action could shift policy. An approach is needed that incorporates what Raphael (2009) calls a political movement-based approach. The concepts, models and literatures below will assist in expanding, what could be called a “political action repertoire” (Greer et al., 2017, p. 42).

5.3 Theories that Inform Political Action

A number of concepts, theories and literatures exist that to this point have not (or only rarely) intersected with the literature on Australian immigration detention. These theories not only help in reconceptualising how health and healthcare are approached in relation to Australian immigration detention, they also provide a broader foundation for future action. They will be introduced here and applied in Chapter 6. I will also discuss why these theories help overcome the limitations discussed above and in Chapter 3 and why they provide a far more robust platform for action in pursuing the standards outlined in Chapter 2.

5.3.1 The Humanitarian Border

While there has been extensive research that has examined border enforcement globally, only recently has attention been drawn to humanitarian measures taken at the border. Walters (2011) has discussed the emergence of what he terms the ‘humanitarian border’. This is a zone (or zones) of humanitarian government along the territorial edges of nation-states, often the political space separating rights holders and non-rights holders. The humanitarian border is related to other forms of governmentality such as surveillance, securitization, and

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64 In expanding the repertoire of potential action that could be drawn upon, this of course does not mean that the concepts and guidelines discussed in earlier chapters are irrelevant or should be discarded. This will be discussed below.
militarization, and it has expanded largely because of the increasingly punitive response toward asylum seekers and refugees. While primarily concerned with alleviating suffering, the humanitarian border does not necessarily work in opposition to securitisation and militarisation; it may in fact shape and expand restrictive border policies. According to Walters (2011), this is a novel and important development in the history of borders and border-making related to increasingly restrictive border regimes and the securitization of migration more broadly:

But if humanitarian government operates on a space that appears to be already securitized, militarized, fortified, etc., it should not be understood as a simple two-step process, a matter of action and response—as though first there is securitization and then humanitarianization, which comes along to sweep up the human collateral damage. While such a view is not without justification, it fails to capture the way in which tactics and counter-tactics play themselves out at a more molecular level. For instance, there are frequently occasions on which security practices and effects materialize within the institutions and practices of humanitarian government (Walters, 2011, p. 147).

While the actors engaged in Australian immigration detention are not humanitarian in the traditional sense, there remain a number of parallels, and the concept of the humanitarian border is useful for a number of reasons. First, it shows how humanitarian rhetoric and action may be co-opted for other purposes (for example, “stopping the boats to save lives at sea”). Second it helps locate Australian immigration detention amongst the larger issue of global justice and border control and in doing so it provides a means to examine the shortcomings of humanitarianism and the roles of clinicians and healthcare broadly within this, along with how they contribute to and legitimise broader injustices.

In Australia and globally there has been a rise in humanitarian justifications for increasingly restrictive border policies (Glynn, 2016; Little & Vaughan-Williams, 2016). The language of humanitarianism has been co-opted by both major political parties. For example, when the Labor government dismantled the original Pacific Solution, it justified it as being a more humanitarian approach (Glynn, 2016); and when both the Labor and Liberal governments re-instated the Pacific Solution, they did so on the pretext of stopping further boat arrivals as a means of furthering a humanitarian agenda. Former Prime Minister Tony Abbot re-enforced this a number of times, even stating that stopping boat arrivals was “[t]he most compassionate
thing we can do” (Hurst, 2015b, para. 4). As explained by Little and Vaughan-Williams (2016, pp. 548-549):

The Coalition elected in 2013 was being more humanitarian through the implementation of Operation Sovereign Borders. Therefore, according to this narrative, by stopping the boats, the government was preventing potential immigrants from arriving on Australian territory and therefore ensuring more humanitarian outcomes than would otherwise be the case if their critics were in government. In other words, border security policy designed to ensure that outsiders did not arrive in Australia (and their subsequent offshore detention in unsavoury conditions) was having the effect of being humanitarian and therefore guaranteeing that the common human rights of all were being better protected.

So what does this mean for humanitarianism? Are boat turn backs more humane? This narrative often starts with asylum seekers boarding a boat but fails to consider other border controls put in place by the government that have led to dangerous travel (Nethery et al., 2013; Weber, 2007, 2013). As was discussed in Chapter 1, Australia has numerous extra-territorial border controls that restrict arrivals by other means. So while saving lives at sea is undoubtedly the right thing to do, the government itself could prevent many of these journeys taking place. This argument also presents a false dichotomy, namely that increasingly punitive policy is the only way to save lives at sea. Little and Vaughan-Williams (2016, p. 550) suggest that:

In seeking an alternative strategy for critical engagement, therefore, we suggest that it is more effective to think about what humanitarian borderwork does as a logic of governmentality and performative political practice. What is important in this regard is to note that the form of political subjectivity produced is one that is taken outside of space and time and rendered effectively context-less. The ‘irregular’ migrant in need of saving by border security authorities is interpellated as a subject that is not only denied any political agency, but also devoid of any connectivity with wider social relations.

Most importantly the humanitarian border also provides a foundation on which to critically reflect on the shortcomings of the actors engaged in this area (Ticktin, 2011, 2014). As discussed above, while the majority of the literature focuses on the day-to-day dilemmas faced by clinicians, there has been little consideration as to how clinicians and healthcare more
generally have shaped and expanded Australia’s policies. Thinking in terms of the humanitarian border allows for broader scope. It allows us to move beyond the clinician-focused dilemmas of dual loyalty and complicity to the larger issue of global justice. In other words thinking in terms of humanitarian borders allows for a consideration of how action can re-enforce policies like mandatory detention and how it may not always “begin to challenge the structural causes of boat migration” (Pallister-Wilkins, 2015, para. 5).

5.3.2 Public Health Ethics

A core value of public health ethics is justice. This makes it suitable for dealing with issues facing refugees and asylum seekers (and migration more generally) (Wild & Dawson, 2018). This also means that public health ethics is also well placed to challenge systemic disadvantage or, in the case of Australian immigration detention, systemic harm. One of the major criticisms from Chapter 3 was that in current approaches, issues of justice and rights are frequently reduced to clinical dilemmas; health is often conceptualised narrowly, from a biomedical perspective and individual clinicians are held to be responsible for resolving irreconcilable dilemmas. Public health ethics is well placed to address these issues, putting injustice first and clinical dilemmas second, focusing on the determinants of health, emphasising the importance of the environment or system rather than just the individual. It is also equipped to deal with political power. As McNeill (2003, pp. 495-496) argues:

Public health is about the exercise of power. If power is to be used for the health of the public, then abuse of power is of concern, both in the sense of abuse of power in the exercise of public health coercive powers, and also in the sense of abuse of power by others in a way that has harmful consequences for the health of others.

Public health ethics provides a theoretical foundation for a more sophisticated political response that can begin to deal with the complexities and politicised nature of this problem. It has the potential to challenge governments, influence the public and not only change attitudes, but lead to policy change. While public health is not incapable of challenging recalcitrant governments, as McNeill (2003) discussed above, its more traditional repertoire of action may
not be adequate in combatting the issues found in Australia. Solidarity and social movement theory, stand to bolster this approach, recognising that change may only come by employing more adversarial action.

5.3.3 Solidarity

Solidarity has a close relationship with justice and human rights. It has been called “a precondition to human dignity, the basis of all human rights, and… development” (UN General Assembly, 2010, p. 18). It has also played a role in the work of the UN since its inception, “drawing together nations and peoples to promote peace and security, human rights and development” (OHCHR, 2011, para. 4). The issues facing refugees and asylum seekers globally have been called a crisis of solidarity (Ki-Moon, 2016) with many authors noting that at the heart of Australia’s approach lies a crisis of solidarity (Tazreiter, 2017).

Solidarity has merit for a number of other reasons. It has been labelled the most important—if not the only—weapon of the powerless. It separates those “who struggle for justice from those… who sympathize but reject direct action” (Kolers, 2016, p. 1). Solidarity shifts the focus of the problem from a “refugee crisis” to a “crisis of solidarity” and, thereby, to those who have an obligation to assist. It has received growing attention against a backdrop of complex global crises and an increasing realisation of shared vulnerability (Prainsack & Buyx, 2016). For Kolers (2016) solidarity is not just important; it is an obligation because it provides a basis upon which equity can be claimed for those have been wronged.

Solidarity has been defined as “political action on others’ terms” (Kolers, 2016, p. 5) or an “enacted commitments to accept costs to assist others with whom a person or persons recognise similarity in a relevant respect” (Prainsack & Buyx, 2016, p. 43). Prainsack and Buyx (2016) go on to outline three “tiers” of solidarity; interpersonal solidarity, defined as the “willingness to carry costs to assist others” (p. 55); group solidarity, defined as a “collective commitment to carry costs to assist others;” (p. 55); and when solidarity becomes institutionalised as contractual, legal or administrative norms.

There is however an increasing recognition of the role that contentious political action and social movements play in public health (Pastor, Terriquez, & Lin, 2018). It is likely that these literatures will increasingly find common ground.
Dawson and Jennings (2012, p. 73) see solidarity as a “a deep and enmeshed concept, a value that supports and structures the way we in fact do and ought to see other kinds of moral considerations”. They reject the idea that costs are a necessary component of solidarity and argue that Prainsack & Buyx’s (2016) definition of group solidarity is the most important. They go on to describe four dimensions of solidarity, one foundational (“standing up beside”) and three relational (“standing up for”, “standing up with” and “standing up as”). “Standing up beside” suggests that solidarity requires an active, intentional, public engagement that positively identifies with others and their position. Relational aspects highlight other ways that solidarity can be expressed. “Standing up for” includes representing, acting or advocating on behalf of others. “Standing up with” emphasises equality between parties and an openness “to other ways of thinking and living” (Dawson & Jennings, 2012, p. 75). The strongest degree of affiliation with others, “standing up as” can be grounded in the shared biological nature of human vulnerability but also in a “shared polity or culture that requires a shared commitment to equal respect, civil discourse and tolerance of difference and disagreement” (p. 75). Jennings and Dawson (2015, p. 37) explain that this expression of solidarity however does not entail the loss of identity or diversity, but rather that the solidarity of standing up involves, “finding a kind of covering connection that does not negate diversity at all but, rather, establishes the grounds of its respect, protection, and perpetuation”. They go on to argue:

Solidarity counters a narrative of independence with one of interdependence. Solidarity recalls the structural context of individual agency and the functional integration that is necessary to that agency. It has to do with the social glue that gives the creativity of action and agency stability. It has to do with the cultural and symbolic order that gives creativity and agency meaning. And it has to do with the historical memory and tradition that give continuity to innovative action aimed at future promise, thereby binding past, present, and future (Jennings & Dawson, 2015, p. 34).

Solidarity thus goes beyond compassion or empathy and according to all definitions, it has two related but distinct components: embracing the cause of others and acting with them or on their behalf (Dawson & Jennings, 2012; Kolers, 2016; Subašić et al., 2008; West-Oram & Buyx, 2016). In this respect solidarity is “fundamentally political—it involves perceiving the social world and acting in a way that challenges existing power relations between groups and, in particular, the decisions, actions, and policies of those in positions of established (hitherto unquestioned) legitimate authority” (Subašić et al., 2008, p. 331).
Beyond its definition, solidarity has also been conceptualised as a process (Subašić et al., 2008). In this process, solidarity occurs when the “minority’s cause becomes endorsed by the majority to such an extent that they become willing to collectively challenge the authority” (Subašić et al., 2008, p. 331). Thus this conceptualisation of solidarity as a process is also political and entails “the development of a shared political orientation to the status quo and a sense of common cause between the minority and the majority, manifest in the willingness to act collectively to challenge existing intergroup power relations and achieve social change” (Subašić et al., 2008, p. 331). Solidarity, when conceptualised this way overcomes a number of the shortcomings in the existing literature that has largely examined social change through what Subašić et al. (2008) calls a conflict or cooperation lens. Social conflict research conceptualises the minority as the focus of social change and thus focuses on the conflictual nature between the minority and those in power. Cooperative social change explores how the majority-minority relationship may be enhanced through processes such as prejudice reduction. An implicit assumption within this work is that understanding the status quo in intergroup relations gives insight into the process of social change (Subašić et al., 2008). There has been little consideration of how these processes affect each other by contributing to or hindering social and psychological change in intergroup relations. The anti-prejudice literature for example has largely focused on “the relationship between the prejudiced majority and the disadvantaged minority” (Subašić et al., 2008, p. 333) failing to take into account “intergroup power relations in which prejudice may serve a particular function, in particular for those who directly benefit from an unequal intergroup hierarchy” (Subašić et al., 2008, p. 333).

While there is a growing body of research and a growing recognition of the importance of solidarity in relation to global refugee issues, in Australia there has been a disconnect between the literature and action designed to build solidarity. In Chapter 6 I will return to Subašić et al.’s (2008) conceptualisation of solidarity, along with how it may be applied in the Australian context. This has a number of advantages over other, largely descriptive, conceptualisations of solidarity discussed above. Like Dawson and Jennings (2012) this framework emphasises group solidarity and while it cannot account for different expressions of solidarity, it can account for other attitudes between groups, such as apathy, sympathy and hostility. Most

66 It is also important to keep in mind that particular processes and questions require our conceptualization of intergroup relations to go beyond in-groups and out-groups defined in static and unidimensional ways (Subašić et al., 2008).
importantly however Subašić et al.’s (2008) model is most useful when attempting to chart a course of action. It sees the relationship between groups as dynamic and changeable, through both cooperative and conflictual processes. It thus moves beyond conceptualising solidarity as an end, instead seeing solidarity as something that can be constructed.

5.3.4 Social Movement Theory and Contentious Politics

Social movements form in the face of injustice and recognise that change must be fought for. Like other social movements, such as the civil rights movements, feminist movements, gay rights movements, the issues facing those seeking change in relation to Australian immigration detention are fundamentally about justice and recognition.

Social movements can be defined as “collective forms of protest or activism that aim to affect some kind of transformation in existing structures of power that have created inequality, injustice, disadvantage, and so on” (G. Martin, 2015b, p. 1) or “collective challenges, based on common purposes and social solidarities, in sustained interaction with elites, opponents, and authorities” (Tarrow, 2011, p. 9). In short, social movements are collective sustained action that attempts to bring about social, cultural or political change (Della Porta & Diani, 2009, 2015; G. Martin, 2015b). Similarly, and closely related, contentious politics takes a more expansive form and can be defined as “episodic, public, collective interaction among makers of claims and their objects when: (a) at least one government is a claimant, an object of claims, or a party to the claims, and (b) the claims would, if realized, affect the interests of at least one of the claimants or objects of claims” (Tarrow, 2013, p. 1). Contentious politics thus includes traditional movements but also accounts for less sustained forms of contention such as riots, strikes and more extensive ones such as wars and revolutions. It also intersects with more routine political processes such as elections (Tarrow, 2013).

Social movement theory is particularly well suited to inform action in response to Australian immigration detention. While not the only theory of social or political change, it overcomes a number of the shortcomings discussed above and in Chapter 3. It is based on the premise that there will be, at least some resistance to demands for change. It thus emphasises grassroots political action. It complements existing approaches and explains some of the more contentious action that has happened to date in response to Australian immigration detention. Most
importantly it provides a more sophisticated foundation on which social action can be planned and pursued. I discuss this in an article included in my portfolio of published work\textsuperscript{67}:

Among a number of other insights, the social movements literature provides a starting point to begin to consider how movements act, how they organize, and the political conditions under which they operate. It has until now been underused. Most fundamentally, this literature moves beyond blunt calls to action or identifying an obvious lack of political will; it recognizes social change as dynamic, complex, and explicitly political (Essex, 2018a, p. 614).

In Chapter 6 I will discuss social movement theory in greater detail along with how it should inform a response.

5.4 Building a Theoretical Repertoire

The introduction of these theories raises a number of questions that have yet to be dealt with, so some clarification is warranted. While I have argued that the theories discussed above provide a far better platform to begin to work toward systemic, social and political change, the theories critiqued in Chapter 3 should not be completely dismissed. There are a number of reasons for this, first and as I argued in Chapter 4, clinicians are likely to continue to work within Australian immigration detention. The literature in Chapter 3 provides a platform to describe the issues faced within Australian immigration detention, including identifying and mediating clinical and ethical dilemmas.

Furthermore, each of the theories and frameworks discussed in the preceding chapters attempts to explain a different part of the problem and each does so in a different way. A single theory cannot account for the complexities of working within Australian immigration detention, let alone the complexities associated with social and political change. Together Selemogo’s (2013) and Lepora and Goodin’s (2013) frameworks provide a starting point to consider a boycott, while Subašić et al.’s (2008) model of political solidarity provides a lens throughout which

\textsuperscript{67}“Health, social movements, and Australian immigration detention” (Essex, 2018a).
social change can be viewed and pursued. Clinicians have an important role to play in both the discussions related to a boycott and in pursuing broader social change. In this respect they should be seen amongst a repertoire of theory that could be used to not only explain these issues, but respond to them.

Importantly the introduction of these theories puts future action in a far better position to pursue the systemic, social and political change outlined in Chapter 2. In Chapter 6 I will focus on an area that has been particularly overlooked, namely, the role of clinicians in social and political change. I will do this by applying Subašić et al.’s (2008) model of political solidarity and Tarrow’s (2011) framework of contentious politics. While the approach discussed above also has implications for clinicians working within detention, I will discuss what this means more practically in Chapter 7.

A final point that is worth discussing before moving on is that the approach I have outlined here does not necessarily mean taking action that is completely unfamiliar. A number of individuals and organisations are already taking contentious political action, for example Doctors4Refugees68, who will be discussed in Chapter 6, have embraced more adversarial action, publicly challenging the government and utilising the media in cases of substandard care (Phatarfod, 2018). The case of Baby Asha (discussed in Chapters 3 and 6) provides another example as do the clinicians who have taken a stand in the face of government power. These are not only examples of how action can be politicised but how clinicians can and should act in the face of a recalcitrant government.

5.5 Conclusions

In this chapter I have outlined a new approach to health and healthcare in relation to Australian immigration detention and introduced a number of literatures that facilitate this approach. I called for a greater focus on justice and rights, rather than the day to day clinical issues and an expansion in the roles that clinicians and professional bodies have outside of detention. I have argued that a movement-based approach can better account for complex social change and assumes what is plainly true: that those in power are not receptive to change. I have also

68 https://doctors4refugees.org
introduced theory that better positions future action to pursue systemic, social and political change. In Chapter 6 I will consider Subašić et al.’s (2008) model of political solidarity and Tarrow’s (2011) framework of contentious politics in more detail and seek to apply them to the issues outlined the preceding chapters. In Chapter 7 I will discuss what this approach means practically for those working in detention and those seeking change more generally.
Chapter 6 Political Solidarity and Social Movement Theory as a Foundation for Action

6.1 Overview

In this chapter I will discuss and apply Subašić et al.’s (2008) model of political solidarity and social movement theory. Broadly, I hope to show how each of these literatures can be used to better understand social and political action. I will first apply Subašić et al.’s (2008) model, outlining how it can inform action related to Australian immigration detention. I will also discuss its shortcomings. I will then introduce Tarrow’s (2011) framework of contentious politics and utilise the insights Subašić et al.’s (2008) model and social movement theory provide to discuss a number of particularly contentious events in detail. I will then discuss what lessons can be generalised from this to inform future action. Finally, while social movement theory and Subašić et al.’s (2008) model of political solidarity say little about what action is justified or why clinicians should act, this discussion will be just as important in planning future action. I argue that within immigration detention and in addition to routine care, advocacy and subversion are justified, these however need to be carefully weighed against any risks or possible repercussions. Similarly, outside of detention I argue that clinicians should not only engage in more familiar forms of action, such as research and advocacy but also consider contentious and adversarial action as part of their repertoire.

Before moving on however, there is a need to discuss the scope of this chapter. While this thesis has discussed clinicians and professional healthcare bodies’ roles in responding and only incidentally referred to other possible actors, the scope of this chapter is expanded in relation to who should take action. Roles within immigration detention are, despite the numerous issues outlined above, contained. That is, there are relatively clear boundaries in relation to the roles of clinicians working in detention. This is not the case when considering the roles of clinicians in broader social change. When discussing social change, multiple social and political factors shape actors, allegiances and action. There are at least two ways to approach this when considering clinicians’ roles. The first is to map a role for clinicians in isolation to others, highlighting where they may be particularly impactful or have particular expertise that may be
useful. The role of other professions and the general public, along with how collaborations and coalitions are formed would be considered secondarily. An alternative is to consider how change can be pursued more broadly, identifying key actors, allegiances and actions and then considering clinicians roles within this broader approach. While this thesis attempts where possible to focus on action relevant to clinicians and professional healthcare bodies, I take the latter approach as the actions of clinicians cannot be considered in isolation of broader social change or the influence of others. It makes little sense to talk about clinicians advocating for the repeal of the Border Force Act (2015), without discussing the role of lawyers and the legal professions. It makes little sense to discuss clinicians marching against immigration detention without considering the impact of thousands of other concerned citizens who amplify such protests. In regards to regional action, the majority of (if not all) clinicians would likely know little about diplomacy, nor how a regional framework should begin to be negotiated.

6.2 Applying Subašić et al.’s Model of Political Solidarity

As was discussed above Subašić et al. (2008) conceptualises political solidarity as a process. The model assumes elements of both conflict and cooperation and a dynamic relationship between the minority (asylum seekers, refugees and their supporters), the majority (supporters or those who are complacent in regards to Australia’s policies) and the authority (the Australian government and other powerful actors). Solidarity occurs when the minority’s cause is taken up by the majority “to such an extent that they become willing to collectively challenge the authority” (Subašić et al., 2008, p. 331). How is solidarity built and how could this apply to the circumstances found in Australia?

Subašić et al.’s (2008) model conceptualises solidarity as a “process of change in intergroup relations” (p. 331). This occurs through a process of self-(re)categorization which “ultimately redefines the authority as out-group and the minority as in-group” (p. 331). Thus fundamental to any change “are the self-categorical relationships between the majority and authority, and majority and minority” (p. 335). In Subašić et al.’s (2008, p. 334) words:

The model conceptualizes social change as a process by which minority dissent against an established authority or, more broadly, the existing system of intergroup relations becomes widespread. It spreads to include those who are not necessarily negatively
affected, themselves, but who nevertheless come to share the minority’s view that a challenge to the status quo is needed.

Within the political solidarity model, at the core of social change is psychological change in people’s understanding of themselves in relation to others. Social identity theory (SIT) (Tajfel & Turner, 1979) and self-categorization theory (SCT) (Turner, 1982; Turner, Hogg, Oakes, Reicher, & Wetherell, 1987) form the basis of this model. SIT and SCT examine different aspects of the conflictual and cooperative elements of social change and together conceptualise social identity as the aspect of the self as it relates to membership in social groups, including the value and significance of such membership (Tajfel, 1974; Tajfel & Turner, 1979). Additionally the self is conceptualised as “being variable, context dependent, and hierarchically organized” (Subašić et al., 2008, p. 337). The hierarchical organisation of identity allows “not only a shift in an individual’s self-perception from personal to social identity (i.e., from me to us) but also a shift in whether relevant others are members of an in-group (us) or an out-group (them)” (Subašić et al., 2008, p. 338). Additionally, inclusiveness can be stratified into lower and higher levels of social identification, with higher order (superordinate) identities (e.g. psychologist) providing the context in which lower order identities are understood (e.g. social vs clinical psychologist). Thus, individual self-categorization processes have the capacity to reflect and shape the social reality of intergroup relations, allowing for a more complex analysis of intergroup dynamics, which goes beyond static in-group–out-group distinctions.

How does the minority cause become the cause of the majority? The hierarchical nature of the self is key in this process: “it is the hierarchical organization of the social self that makes inter-subgroup solidarity (and inter-subgroup division) possible by allowing for subgroup differences to be understood with reference to higher order identity norms, values, and beliefs” (Subašić et al., 2008, p. 338). Also of importance is that identity is often highly contested, in particular higher order identities, as discussed by Subašić et al. (2008, p. 339):

As such, the creation and maintenance of social influence (i.e., power) and authority involve the meaning of identity (including higher order identity) within intergroup power relations being continually contested rather than given. As such, the struggle between the authority and the minority for the hearts and minds of the majority could be seen as a contest for the definition of the higher order identity—the norms, values, and beliefs that define who we are.
Whether a challenge to the status quo occurs depends on the identification between a number of groups. Change within Subašić et al.’s (2008) model occurs within a context of intergroup power relations and involves at least three social actors: minority, authority, and majority, with these positions defined primarily by their social positions and relative power. Somewhat obviously, the minority is conceptualised as having a relative lack of social power whereas the authority holds power over the majority. For Subašić et al. (2008, p. 335) the majority “simply denotes those who are neither in the position of authority or minority but rather are the target audience for these actors in their quest to maintain the status quo or achieve social change, respectively, in intergroup power relations”69. Thus how the majority self-categorize is influenced by both the minority and authority with change occurring when “members of the majority self-categorize in a way that makes possible challenge to authority in solidarity with the minority” (p.336). Authority maintains its legitimacy by being perceived to share “relevant norms, values, and beliefs with the majority” (p. 335) and will be challenged if “seen to act in a way that violates what “we” believe to be the proper conduct in a given social context” (p. 335). As such, whether the status quo or social change occurs depends on whether there is a shared social identity between either the authority and majority or the minority and majority.

This of course is more complex than reducing this relationship to three dualisms, Subašić et al. (2008) proposes a tripolar intergroup dynamic where future action will depend on the majority’s attitude toward both the authority and minority. For example if the majority have a shared social identity with the minority but also with the authority, it may result in little more than sympathy for the minority. Only when the majority no longer identify with the authority will challenge occur. It is solidarity with the minority, rather than merely rejection of authority, that makes majority challenge to the status quo possible. This is illustrated in figure 6.1 below.

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69 This of course does not mean the majority (or any group for that matter) is a homogenous group. Within the majority there are likely to be a range positions in relation to both the authority and minority. This diversity within the majority can lead to a set of intragroup processes parallel to that of broader intergroup processes.
Subašić et al. (2008, p. 342) considers how this applies to Australia’s treatment of refugees and asylum seekers:

…although people may perceive that detaining and deporting asylum seekers is quite harsh and even identify with this group in terms of their suffering, this policy will not be challenged by the majority as long as such authority actions are seen as legitimately fulfilling other needs (e.g., enhancing national security). Under such conditions, and given the self-categorical asymmetry between the majorities relationships with the authority and minority (see above), the minority will, at best, elicit the sympathy of the majority and actions of the authority will not be challenged. However, perceptions that authority actions are unfair or illegitimate (because they violate important norms and values and, therefore, a shared understanding of who we are) make the status quo unsustainable in the long run (Tajfel & Turner, 1979), in particular if the authority does
nothing to maintain its legitimacy in other ways and identification with the minority strengthens. As such, this dynamic may, over time, become one of political solidarity with the minority.

6.2.1 A Caveat on Political Solidarity

Even though Subašić et al.’s (2008) model of political solidarity provides an improved theoretical foundation on which systemic, social and political change could be pursued, there remain a number of caveats. First, careful consideration still needs to be given to the range of historical, social and political factors that frame the actions of the minority, the majority and those in power. Shared vulnerability, such as threats of terrorism and insecure employment for example, may be powerful motivators to challenge the status quo. Self-interest and the proximity of the minority (spatially and otherwise) may also have an impact (West-Oram & Buyx, 2016). In this respect, this model does not point to a specific repertoire of action, and leaves open the question of precisely what action, at what time under what circumstances would be effective. A number of other considerations that affect whether action will take place, such as self-efficacy and intergroup emotion. These are not accounted for within this model, but remain important considerations in relation to whether action will occur. Questions also remain about intragroup dynamics. Clinicians would only make up a small portion of the minority (asylum seekers, refugees and their supporters), so it will be necessary to work with the general public and others who are concerned about these issues. What roles should clinicians have in this respect? This is only complicated by the fact that clinicians are not a cohesive group. Many are likely to remain apathetic or even hostile to refugees and asylum seekers. The important question of how to galvanize support within the medical community also needs to be addressed. Finally, this model doesn’t outline what action would be justified or why clinicians should act. This will be discussed toward the end of this chapter, after turning to social movement theory, a literature that helps to fill some of these gaps.

70 Bandura (1982, p. 122) defines self-efficacy as a judgement of “how well one can execute courses of action required to deal with prospective situations”.

71 According to intergroup emotions theory, emotional experience is closely related to self-categorisation. Thus, people experience different emotions, when they self-categorize as part of a group (Mackie, Smith, & Ray, 2008).
6.3 Applying Social Movement Theory

There is an extensive literature on social movements and contentious politics, including a literature that has focused on social movements in Australia (G. Martin, 2015b). However, while Australian immigration detention has galvanised a number of social movements and has been one of the most contentious political issues in Australia, these literatures have rarely met. Exceptions include Tazreiter (2010) who provides a descriptive account of social movements in response to the Howard government in Australia from 1996-2007 and Gosden (2006) who also examines the rise of an asylum seeker and refugee advocacy movement. A number of other authors have examined contentious political action in response to Australian immigration detention which complements this literature. For example, the #LetThemStay campaign which will be discussed below (Hall et al., 2018) and protest within immigration detention centres (Fiske, 2016a, 2016b).

In this section I will first introduce Tarrow’s (2011) framework of contentious politics. This framework is expansive and arguably explains all key elements of social movements and contentious politics. Because of this however, I have focused on elements that are particularly relevant to the issues found in Australia. Next I will utilise the insights that social movement theory and Subašić et al.’s (2008) model provide to discuss a number of particularly contentious events that have occurred in response to Australian immigration detention. I then will discuss what lessons can be generalised from this to inform future action. Finally, social movement theory says little about what action is justified or why clinicians should act. I will discuss each of these points, outlining why clinicians should consider contentious and adversarial action as part of their repertoire and why they have a responsibility to take such action.

Tarrow’s (2011) framework is a synthesis of political process theory (Tilly, 1978) and insights from other branches of social movement theory. This theory accounts for isolated acts of contentious political action, sustained contentious political action (or social movements) and broader cycles of contention, explaining the dynamics of contentious political action. Tarrow’s (2011, p. 16) approach to contentious politics is best summed up in his words:

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As was discussed in Chapter 5, contentious politics includes a more expansive range of action than traditional social movements.
... contentious politics emerges in response to changes in political opportunities and threats when participants perceive and respond to a variety of incentives: material and ideological, partisan and group-based, long-standing and episodic. Building on these opportunities, and using known repertoires of action, people with limited resources can act together contentiously – if only sporadically. When their actions are based on dense social networks and effective connective structures and draw on legitimate, action-oriented cultural frames, they can sustain these actions even in contact with powerful opponents. In such cases – and only in such cases – we are in the presence of a social movement. When such contention spreads across an entire society – as it sometimes does – we see a cycle of contention. When such a cycle is organized around opposed or multiple sovereignties, the outcome is a revolution.

Tarrow’s (2011) framework accounts for the features of collective action, namely, repertoires of political action, how people network and organise, how they construct their grievances and make meaning, and how they respond to threats and capitalise on opportunities. It also incorporates the relational nature of social movements and contentious politics, explaining the mechanisms and processes of contention and how contention cycles. Tarrow (2011) argues that the outcome of contentious action cannot be predicted by examining what a single movement does at a single point in time. They must be seen in relation to those in power, their allies and more generally the context in which they operate. I will discuss key elements of his framework below with specific reference to Australian immigration detention and the social and political action surrounding it.

6.3.1 Features of Contentious Politics

The most obvious starting point in discussing social movements and contentious politics relates to the type of action individuals and groups employ. Tarrow (2011) argues that action fits into three categories—disruption, violence and contained action—and that the type of action employed will often shift over time, in response to opportunities and threats.

Each type of action comes with its own relative strengths and trade-offs. Tarrow (2011, p. 103) calls disruption the “strongest weapon” of social movements because of its ability to give actors leverage and spread uncertainty. Beyond this leverage, however, disruption can also show the determination of a movement and re-enforce solidarity within the movement (Tarrow, 2011).
While such action can broaden the arena of conflict by, for example, blocking traffic, interrupting the general public and impacting law and order, it need not do so and may include non-violent direct action such as sit-ins. Disruption however is not the most durable form of action. It requires a high level of commitment; it can be shut down easily and, over time, movements tend to move toward more contained forms of action (the reasons for which will be expanded upon below). There are numerous examples of disruption both within immigration detention centres and externally. Within detention, lip-sewing and hunger strikes are examples of disruption (Fiske, 2016a). External disruptions include blocking deportations (Australian Associated Press, 2016b, 2016c) interrupting parliament (Hutchens, 2016; Karp, 2016b) and sit-ins (see Love Makes a Way73 and Mums4Refugees74). A boycott, discussed in Chapter 4 is a further example of potentially disruptive action. The majority of this action has been to at least to some degree planned, however there have been instances of improvised action (Australian Associated Press, 2016c).

Disruption risks slipping into conflict and violence. While violence can be easy to initiate under the right circumstances, it is equally as easy to supress. Furthermore it is often limited to small groups with limited resources who are willing to risk repression or damage (Tarrow, 2011). Occasionally protest against Australian immigration detention has escalated to violence. The most notable example has been riots within detention centres (Fiske, 2013, 2016a). Riots have led to deaths, injuries and millions of dollars in damage to detention centres (Australian Associated Press, 2013; Ellis et al., 2016; Fiske, 2013, 2016a). They have been quickly suppressed and their impact has been short-lived.

Tarrow’s (2011) theory of contentious politics also accounts for more contained action, which largely encompasses what I referred to in Chapter 5 as “professionally-oriented rational or knowledge-based approaches” (Raphael, 2009, p. 145). As well as being more likely to be tolerated by those in power75, contained action can also engage large numbers of people as it is a form of action that people understand and know how to use, that involves relatively little commitment and low risk (Tarrow, 2011).

73 http://lovemakesaway.org.au
74 http://www.mums4refugees.org
75 Which could arguably be a strength or weakness depending on the circumstances.
A final point of discussion that is particularly relevant to the circumstances in Australia relates to what action has been accepted or challenged by the government. While repertoires change and while action can become accepted and institutionalised, every polity draws lines between collective action that is forbidden, permitted, or facilitated (McAdam, Tarrow, & Tilly, 2003). Action protesting the harms of Australian immigration detention, which would be tolerated under other circumstances, is frequently challenged or attacked. For example, while accounts of abuse and violence (including against children) would be met with concern under other circumstances, they have been challenged in relation to immigration detention (Hurst, 2015b). This sensitivity to criticism has not silenced critics and could be seen as an opportunity, as will be discussed below.

The second feature of contentious politics relates to how movements are organised and how they (and challengers more generally) network. Movements may be formal or informal, centralised or decentralised, hierarchical or otherwise. They can even be a hybrid of these things. While there is no single, correct way to organise, what is clear is that if contention is to be sustained, some degree of leadership is required, as are social networks that could survive even if the organisation is repressed or disappears (Tarrow, 2011).

Hundreds of organisations in Australia have called for reform. Some of these organisations are established and deal with a range of issues; others have galvanised around Australia’s policies toward refugees and asylum seekers. Some are formal and structured and focus on lobbying and other contained action (e.g., The Refugee Council of Australia). Some are smaller and more activist and at times involved in disruption (Hutchens, 2016; Karp, 2016b; Mums4Refugees). Networks of concerned citizens have worked within and between organisations and have mobilised around a range of issues. While many organisations have worked together, priorities have differed, as have views on what action may be most appropriate to achieve change. Tazreiter (2010) discusses how during 2001 amongst a climate of increasing hostility toward boat arrivals and the introduction of offshore processing there was criticism of larger organisations who had closer ties with government and who had refrained from criticising this increasingly punitive approach. These divisions remain today. RISE: Refugees, Survivors and Ex-detainees continue to boycott world refugee day, citing

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76 Also for example, the AHRC Forgotten Children Report (2014) which will be discussed below.
77 https://www.refugeecouncil.org.au
78 http://riserefugee.org
the hypocrisy of other organisations for working with the immigration department while they “hold hundreds of our people captive in concentration camps in and outside Australia and push refugee boats back into the sea” (Ex-Detainees Boycott World Refugee Day, 2017, para. 2). They state:

…we urge our communities to give thought before partaking in such activities. We should not be remembered once a year as passive entertainers to satisfy the public’s voyeuristic interest or to satisfy the diversity checklist while our community members are directly or indirectly endangered by these very same entities (Ex-Detainees Boycott World Refugee Day, 2017, para. 2).

Similar issues have arisen within the healthcare professions. First, there has been a lack of consensus on precisely what action should be taken. This is evidenced throughout the position statements and guidelines discussed in Chapter 3 and the disagreements surrounding a boycott discussed in Chapter 4. It is also evidenced in the action that some organisations are willing to take. For example, while professional healthcare bodies have been measured in their response, largely pursuing what was above termed “contained action”, other organisations, such as Doctors4Refugees have been willing to take more assertive action (Phatarfod, 2018). I will discuss this further below.

The third feature of contentious politics relates to how challengers make and manipulate meaning. The literature, among other things, has focused on how movements frame contentious politics within cultural repertoires. This intersects with Subašić et al.’s (2008) model of political solidarity. As was discussed above, this model proposes a tripolar intergroup dynamic. Whether the status quo or social change occurs depends on whether there is a shared social identity between either the authority and majority or the minority and majority. It is worth reflecting on how this could happen. On one end of the spectrum, challengers could (or the minority in Subašić et al.’s, 2008, language) frame their grievances in more radical terms, aiming to galvanize present supporters, and carve a distinct identity. On the other hand

79 Tarrow (2011) draws on a series of papers from Snow and Benford (1988, 1992) to outline the concept of framing, which he defines as “process in which social actors, media and members of a society jointly interpret, define and redefine states of affairs” (Klandermans, 1997, p. 44).

80 This literature has also explored how challengers construct collective identities and how they use emotion to mobilise followers. This literature however is large and intersects a number of disciplines; it is beyond the scope of this thesis to review in its entirety.
challengers could opt to frame their grievances within the bounds of political consensus. Tarrow (2011, p. 147) argues that it is particularly difficult to develop dynamic symbols that can prompt change while “evoking symbols that are familiar to people who are rooted in their own cultures”.

Shenker-Osorio (2015, p. 11) argues that messages can be greatly enhanced by appealing to “Australian mythology and self-perception”. While empirical support exists for this, it creates the tension described above. An example of this can be seen in the “Real Australians Say Welcome” campaign (Sainty, 2015). This street art campaign deliberately co-opted nationalist language, which fundamentally rests on the assumption that there is such thing as a “real Australian”. While provocative and well received, the tension here is obvious:

Today, 'Real Aussies' overwhelmingly support mandatory detention. In the past, Real Aussies displaced, massacred and set up systems which to this day oppress the Aboriginal peoples of this land. Being a 'Real Aussie' is nothing to aspire to. Rather than a blow to Australian racism and white denial, the 'Real Aussies' campaign and its civic nationalist partners is an affirmation of both (Frances, 2016).

Finally, a particularly important feature of contentious politics relates to how challengers respond to threats and opportunities. Opportunities and threats refer to (mostly) external forces that shape contentious politics. Threats and opportunities taken together have traditionally been referred to as a “political opportunity structure” or the degree of openness or closure of the formal political system (Della Porta & Diani, 2009; G. Martin, 2015b). Threats and opportunities however do not exist on the same continuum. Tarrow (2011, p. 32) defines opportunities as, “consistent – but not necessarily formal, permanent, or national – sets of clues that encourage people to engage in contentious politics”. Opportunities are perceived, thus before mobilisation occurs they must be both recognised and communicated (McAdam et al., 2003; Meyer & Minkoff, 2004). Opportunities are also often fickle: they can quickly be identified by those in power and quickly limited or closed. Tarrow (2011, pp. 164-165) suggests that the most critical factors in fully capitalising on opportunities include “(1) opening of access to participation for new actors; (2) evidence of political realignment within the polity; (3) availability of influential allies; and (4) emerging splits within the elite”.
Tarrow (2011, p. 32) describes threats as “factors – repression, but also the capacity of authorities to present a solid front to insurgents – that discourage contention”. Threats can be conceptualised as the costs of action or inaction. For example, a group may decide to protest even if there are many risks if they also perceive the chances of success are high (Goldstone & Tilly, 2001). In other cases, however, groups may “decide to avoid even modest costs of protest if it believes the chances of succeeding are low” (Tarrow, 2011, p. 183). Threats may be actual or threatened, physical or social, overt or covert. The response from those in power could also be described as either coercion or channelling (Earl, 2003). Coercive measures include military action against protests, policing of protests, counterintelligence and violence by countermovements. Historically, with the shift to non-violent protest and both broader acceptance of protest and the increasing ineffectiveness of coercive controls, authorities have turned to “channelling” (Earl, 2003). Channelling includes action such as cutting off funding, passing legislation, creating requirements for protest, financial aid and restrictions and limiting goals and tactics.

The Australian government has employed both coercion and channelling in response to resistance and dissent related to immigration detention. Examples include increased surveillance, threats of prosecution including police searches (Farrell, 2015d, 2016), limiting oversight (Jabour & Hurst, 2014) and legislation to silence dissenters (Hoang, 2015). These threats, however, have not always been effective. In the face of increasing suppression, more and more people have felt compelled to act or speak out of their experiences in relation to immigration detention. This paradox, that repression often fuels movements is well recognised in the literature and can be seen throughout history (Kurtz & Smithey, 2018).

Regime change adds a further, but also more stable element to opportunity and threat considerations. Tarrow (2011, p. 161) describes regimes as consisting of “regular relations among governments, established political actors, challengers, and outside political actors, including other governments” and regime change as “change that inserts new actors into these relations, reduces the power of regime members, or imposes new relations among them”. Regime change can influence a state’s strength or how it deals with challengers (Kriesi, 1995). While there is now bipartisan support for offshore processing, arguably the best opportunity for lasting reform since the introduction of immigration detention came after the Rudd

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81 These issues were discussed in greater depth in Chapter 1.
government came into power in 2007 and dismantled the Pacific Solution (discussed in Chapter 1). Unfortunately these changes were short-lived.

6.3.2 The Dynamics of Contentious Action

The preceding discussion has largely explained elements of contentious politics in isolation. What remains unaccounted for is how they these elements interact and how external and internal forces can shape the trajectory of social movements more generally. The dynamic aspects of contentious politics are considered below. This section will focus on major processes found in all movements, mobilisation (and demobilisation), campaigning, coalition formation, and diffusion.

Mobilisation is the precursor to contentious action. There are four main processes that lead to mobilisation. Challengers first interpret and frame the field of contention. Challengers and those in power perceive opportunities and threats, create resources and organisations to take advantage of opportunities (and ward off threats) and engage in innovative action to attract supporters and impress or threaten authorities. Five mechanisms are important in relation to demobilisation. Repression or control of contention, facilitation, satisfying some claims of the contenders, exhaustion, and two linked but opposing mechanisms, radicalisation and institutionalisation (Tarrow, 2011).

A campaign is a sustained and organised public effort that makes targeted claims on those in power (Tilly & Tarrow, 2007). It can involve new actors, those previously uninvolved or even activate existing coalitions, who come together around collective claims and disperse when the campaign is over. The “No Business in Abuse” and “Real Australians Say Welcome” (Sainty, 2015) campaigns are two examples. Many more campaigns have been coordinated and promoted by existing advocacy organisations. For example, the Asylum Seeker Resource Centre has promoted a number of campaigns, including #LetThemStay, #RightTrack and #BringThemHere.

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82 This of course is a very brief summary of each of these phenomena. Much more could be said and much more is said by Tarrow (2011). This brief explanation however is sufficient for the purposes of this chapter.
A second key process is coalition formation. Coalitions can be defined as a “collaborative, means-oriented arrangements that permit distinct organizational entities to pool resources in order to effect change.” (Levi & Murphy, 2006, p. 654). A coalition may come about for a range of reasons including a desire to pool resources (Staggenborg, 1986), to fight a common enemy (McCammon & Campbell, 2002) or to create and re-enforce solidarity between challengers (Van Dyke, 2003). Thus the incentives to form a coalition are multiple, helping groups gain numbers, legitimacy and influence against those more powerful (Hathaway & Meyer, 1997). While many organisations have stood side by side presenting a united front against immigration detention any impact this has had has been short lived and coalitions in Australia have failed to make a meaningful impact (Doherty & Farrell, 2015; Slezak, 2017). Many continue to disagree on how these issues should be approached and what trade-offs, if any, are needed (also see above discussion regarding organisations and networks).

Social movements can also expand their own opportunities and those of others, including other challengers and those in power. This can be done by demonstrating action to other groups or even exposing weaknesses that may not have previously been evident (Tarrow, 2011). On the other hand however, increased opportunities can also lead to counter movements. Sometimes, contention diffuses to different levels of the polity, where actors encounter a different set of incentives and constraints, sometimes even spreading to other states or to international institutions. This is what has been called “scale shift” (Tarrow & McAdam, 2005). Scale shift is vertical diffusion, rather than horizontal and it can shift “contention upward in a polity” (Tarrow, 2011, p. 193). The case of Baby Asha provides an example of this, which will be discussed below. This is in contrast to the slower mobilisation and diffusion that occurred in the 1990s when many movements were emerging (Tazreiter, 2010).

A cycle of contention is a “phase of heightened conflict across the social system” (Tarrow, 2011, p. 199). At its height a cycle involves rapid diffusion of action across individuals and organisations, rapid innovation in the form of action employed, the creation of new frames and an increased flow of information between challengers and those in power. This all serves to give challengers a temporary advantage, forcing powerholders to respond with broader strategies that may either be repressive, facilitative or a combination of both (Tarrow, 2011). Social movement campaigns (those generally focused on one issue) also cycle. These do not necessarily overlap with “broader society-wide cycles of contention, but aggregate to form them” (Tarrow, 2011, p. 199). While cycles of contention may be noted for their far reaching
claims and broad impact, they often have relatively humble beginnings, claims are generally narrow or focused on one issue (Tarrow, 2011).

Cycles have different phases of opportunity and constraint, with many static and dynamic concepts already discussed above. Opportunities open and close. Cycles also witness innovation in the forms of action taken. Often the most prominent feature of a cycle of contention however is diffusion, engaging groups that would otherwise be more quiescent and have few resources to engage. The end of a cycle can be described as “re-stabilisation” with the relationship between actors becoming more stable and routine (Koopmans & Olzak, 2004). Two mechanisms that lead to this stabilisation—repression and facilitation—interact with the processes of institutionalisation and radicalisation that are already under way (Tarrow, 2011).

While there have been phases of heightened protest in relation to Australian policies relevant to asylum seekers and refugees, there has yet to be a full cycle of contention. Tazreiter (2010) describes increasing mobilisation after 2001 as a “slow burn”. While numbers of organisations have proliferated since the early 1990s, and while there has been increasingly forceful action in response to increasingly harsh policy including isolated incidents of protest, rarely has a “phase of heightened conflict across the social system” (Tarrow, 2011, p. 199) been sustained.

6.3.3 Contention Beyond Borders

Contention may also spread beyond borders with contentious politics increasingly having a transnational focus, focusing on issues such as global justice. The issues faced by asylum seekers and refugees go beyond Australia’s borders to the Asia Pacific and globally. Ataç, Rygiel, and Stierl (2016, p. 528) suggests that what is seen globally can be “thought of as connected and global struggles for and of movement” with refugee and migrant protest growing throughout several countries and border regions (Ataç et al., 2016). Australia is of course not insulated from this growing contention, with a growing international recognition of Australia’s approach as uniquely harsh (Laney, Lenette, Kellett, Smedley, & Karan, 2016).

Looking to the future Tarrow (2011) argues that at least five processes will become increasingly important: 1) The use of domestic protest to pressure governments to take action against external threats; 2) the use of external protest to shape domestic issues; 3) domestic
issues will increasingly be framed globally; 4) the diffusion of action across borders, and 5) the creation of transnational networks to shape action across borders.

6.4 Australian Immigration Detention Through the Lens of Social Movement Theory

In understanding how social movement theory could inform future action, it is worthwhile examining past contentious action in detail.

There are several interesting examples of opportunities that have been exploited (often unintentionally) in relation to Australian immigration detention. After the AHRC Forgotten Children Report (2014) was released, the government went on the attack, calling for the resignation of the then Commissioner, Gillian Triggs (Borrello & Glenday, 2015). This report, while shocking, said little that was not already known. So why was there such a vitriolic reaction that inevitably only increased the profile of this report? A number of external factors explain this. The government at the time was on the defensive, attempting to justify its policies against ongoing reports of violence, assault, riots, self-harm and suicide. The then Prime Minister, Tony Abbott was particularly sensitive to criticism, blaming the issue of children in detention on the previous government, and even dismissing international calls for reform (Kozaki, 2015). This report came at a time when the government was actively attacking the credibility of alleged whistle-blowers and was soon to pass the Border Force Act (2015) (Doherty & Davidson, 2016; Farrell, 2015d, 2015e). The focus of this report was also a more vulnerable group (children and families) where public emotions could more easily be tapped. Thus, it was not the report itself which added anything shockingly new to the debate, but a range of external factors that led to this report gaining significant attention. Through the lens of social movement theory, these circumstances could be seen as an opportunity to place increasing pressure on the government. While protests ensued after the release of this report and children were eventually released from onshore detention in May 2015 (Australian Border Force, 2015), one can only speculate upon the impact of more coordinated leaks and whistleblowing.

As was discussed above, violent repression of movements has historically undermined the legitimacy of those in power (Kurtz & Smithey, 2018). Can the same be said about how the
Australian government has responded to challenges to immigration detention? For those detained, the government seems to be able to act with impunity, that is, they continue to purposefully violate their rights while protest has been violently repressed, resulting in deaths and injury (Bourke, 2014; Ellis et al., 2016). While there has been a vocal minority, this has rarely, if ever, led to national outrage. There are however limits. The Border Force Act (2015) provides one example and begins to show not only the limits of government power, but also provides a lesson in framing contention in the Australian context. Some people broke the law\(^{83}\) (Isaacs, 2015c) and challenged the government to prosecute them (The Guardian Australia, 2015). Despite being given every opportunity to do so, the government failed to take offensive action, denying the legislation would have any negative impact and amending it quietly before a legal challenge (Doherty, 2016b). It appeared there were limits to how far the government was willing to go in covering up its abuses. This lack of action stood in contrast to the government’s previous attacks on the AHRC (Borrello & Glenday, 2015), raids on offices of contractors, and referral of clinicians to the Australian Federal Police (also discussed in Chapter 1). So why was no action taken under the Border Force Act (2015)? First, multiple clinicians, academics and professional bodies spoke out against the law, so if the government were to prosecute they would likely have to pursue many people. Furthermore, taking such action would have undermined the government’s legitimacy and supposed commitment to “free speech”\(^{84}\). This also fits with what Subašić et al.’s (2008) model says about regarding violating norms and values. That is, any prosecution would have likely been perceived as a step too far by the general public, drawing further condemnation and serving to galvanize further opposition to these policies. The government might have also held little hope for a successful prosecution given the implied freedom of political communication protected under the Australian constitution (Meagher, 2004) and because numerous high profile lawyers had offered free legal counsel to anyone who was charged.

How this was framed by both the government and those challenging the law was also important. The government justified their attacks on the AHRC, alleging political partisanship (Borrello & Glenday, 2015). Similarly they alleged that the contractors raided on Nauru were leaking information to the media and encouraging self-harm\(^{85}\) (Doherty & Davidson, 2016). Those

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\(^{83}\) Not only broke the law, but publicised and promoted their breaking of the law through the media.

\(^{84}\) For example, this came at a time the government was attempting to water-down the Racial Discrimination Act, under the guise of free speech (Grant, 2017).

\(^{85}\) See Chapter 1; this was later found to be false and those accused were compensated by the government.
seeking to reform the Border Force Act (2015) argued that it would stop clinicians reporting problems such as child abuse and fulfilling other key parts of their roles. While the Border Force Act (2015) could have been challenged as undermining free speech or even violating core democratic norms, it was framed as clinicians simply unable to do their jobs\(^\text{86}\) (The Guardian Australia, 2015). In this sense this argument depoliticised healthcare within detention, as the government has also often claimed to do (i.e., holding that healthcare was provided to an equivalent standard found in the Australian community). This made it particularly difficult for the government to attack or dismiss the concerns of clinicians and professional bodies. While the idea of clinicians being unable to do their job is not new, what was different this time was that clinicians and professional bodies spoke out with the support of the media. Rhetoric that depoliticises the role of health and healthcare can be effective under the right circumstances. As will be seen below, in both the case of Baby Asha and for those seeking medical assistance through Doctors4Refugees, medical opinion when seen as apolitical and promoted by the media, has been difficult to dismiss or challenge.

A further example comes from the relatively impactful #LetThemStay campaign (Hall et al., 2018) which was launched in February 2016. National protests were staged against the transfer of 267 asylum seekers, including 54 children and 37 infants, from Australia to Nauru. This action occurred at the same time of a High Court challenge to the legality of offshore detention and while an infant, who became known as Baby Asha was transferred to Australia and hospitalised (Essex & Isaacs, 2018). Asha and her parents were flown to Brisbane after she was accidentally burnt. Doctors at Lady Cilento Hospital in Brisbane refused to discharge her to be returned to Nauru. The media promoted this case and a protest mobilised around the clock outside of the hospital for 10 days, placing the government under increasing pressure to honour the doctors’ refusal to discharge her (Hall et al., 2018). After negotiations with the government, Asha was discharged to community detention about ten days later. Despite this compromise, the former immigration minister, Peter Dutton, maintained she would eventually be returned to Nauru (Doherty, 2016a; Wahlquist & Murray, 2016). The #LetThemStay campaign was labelled a success, over half of the 267 asylum seekers at the centre of the protests, including 37

\(^{86}\) This is not necessarily at odds with the shift called for in Chapter 5. Future action needs to be strategic in a political sense, this does not mean employing political rhetoric if it is going to be less effective or even harmful. It is also not to say that protest was apolitical or failed recognised the broader implications of this law. Examples of this can be seen throughout the “Open Letter on the Border Force Act” (The Guardian Australia, 2015) which challenged the government to prosecute, the Border Force Act (2015) was largely framed as impeding clinicians in being able to report child abuse or other child protection issues. This letter is included in my portfolio of published work.
babies and their parents, were released into onshore community detention (Hall et al., 2018). This episode of contention however cannot be labelled a complete success, however, because Baby Asha and her family were eventually returned to Nauru several months later (Hall et al., 2018).

A number of things can be learnt from this case. Like the AHRC Forgotten Children Report (2014), a political opportunity was exploited. This opportunity was communicated to others, the media and those already sympathetic to this cause, and they lent support to the doctors who refused to discharge the child. Without the media or the mobilisation of the broader #LetThemStay campaign, the actions of these doctors might have gone unnoticed. Clinicians have often effectively utilised their already powerful positions by engaging with the media. Opportunities are often fickle, however. More recently the government has acted to shut down such opportunities by transferring asylum seekers who need medical treatment to third countries such as Taiwan (Doherty & Vasefi, 2018).

While larger, more established medical organisations have been reluctant to take adversarial action, a number of organisations specifically focused on issues facing refugees and asylum seekers have formed to fill this void. Doctors4Refugees are one example of an organisation that has effectively utilised the media to bring to light cases of inadequate care. Doctors4Refugees President, Barri Phatarfod, provided this account:

One of the first cases we successfully advocated for was that of an 11-year-old boy who sustained a double fracture of his forearm when he fell off his bicycle in Nauru in 2015. The hospital plastered it up and sent him on his way, but after two weeks when he still experienced debilitating pain his mother contacted us with his X-rays. Doctors for Refugees obtained the opinions of various Australian specialists, including paediatricians, orthopaedic surgeons, radiologists and emergency physicians, who all reached the same conclusion: this boy needed an urgent surgical repair (ORIF) to avoid permanent disability and that the time to do this had almost passed. When the Immigration Department essentially fobbed us off, with the permission of the boy’s mother we went to the media – complete with the X-ray. The result was quite astounding. Within a week the Government flew an Australian orthopaedic surgeon (and an entire operating theatre) to Nauru to do the requisite surgery on this young boy.
The absurdity of this expense aside, this appeared to be a successful outcome and almost immediately our group was inundated with requests from others to similarly assist them (Phatarfod, 2018, pp. 15-16)

Finally, how little or how much does this kind of action contribute to systemic, social and political change? In the social movements literature contributions have generally been categorised as having direct impact, indirect impact or having a joint impact, with a range of other factors (Amenta, 2006; Giugni & Yamasaki, 2009; Kolb, 2007) and this is often never clear cut. An example of this uncertainty relates to Australia’s recent announcement that it would ratify the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). Clinicians, healthcare bodies and human rights organisations have long called for increased surveillance within immigration detention, particularly since the re-opening of offshore centres and the ongoing reports of harm from within centres. In late 2015, eighteen professional bodies called for ratification of the OPCAT in news and journal articles (Anderson, 2015; Sanggaran, 2015; Sanggaran & Zion, 2015). In July 2016 ABC News aired a report on the Don Dale Youth Detention Centre, revealing abusive and violent conditions that were likened to torture (Meldrum-Hanna & Elise, 2016). This report caused public outrage, and the government announced a Royal Commission into the Protection and Detention of Children in the Northern Territory shortly afterwards. In February 2017 the government announced that it would ratify the OPCAT (Beech, 2017). What contribution, if any, did those advocating for greater transparency within immigration detention make? While this question may seem beside the point, and it is undoubtedly a good thing that Australia is now ratifying the OPCAT, it shows how social and political action may have a range of unintended and indirect impacts that are often difficult to measure. As put by Tarrow (2011, p. 215):

…few movements “succeed” in achieving their demands in anything like their original form. At best, they contribute to collective goods that benefit those they claim to represent; at worst, the structure of politics through which new claims are processed forces them into a common crucible from which reform is the best they can expect.

87 A Royal Commission is a major public investigation generally into issues that are controversial or have significant public importance.
In addition to the discussion above, two papers included in my portfolio of published work discuss how social movement theory can and should be utilised by clinicians in response to Australian immigration detention\(^{88,89}\). Both call for clinicians and professional healthcare bodies to engage with this literature to inform future action. These papers discuss a number of arguments introduced in previous chapters and the examples of past contentious action, discussed above.

6.5 How Could Social Movement Theory Inform Action?

Beyond the episodes of contention discussed above, what more general lessons can be learnt from social movement theory? First, and most broadly contentious politics provides a way to understand responses to complex social problems and social change. It allows for an exploration of issues across time and place, identifying commonalities, differences, successes and failures. It gives insight into why movements were successful or unsuccessful in achieving their goals. So how might the literatures on social movements and contentious politics inform future responses in relation to Australian immigration detention? A number of conclusion can be drawn.

Social movement theory first and foremost provides a set of concepts that describe social and political action. It moves beyond describing a lack of political will or a simple repertoire of action, identifying key elements of social movements and introducing concepts such as political opportunities, threats and cycles of contention.

Social movement theory allows for reflection on the type of action employed and the reasons for doing so. Movements do not simply cycle through action, moving from one to the next until something works. Civil rights were not won by simply staging boycotts. Movements employ a range of actions, all of which have different impacts and entail different trade-offs. Disruptive action, while drawing attention to a cause, might only serve to further polarise those on either side of the debate. More contained action that is likely to attract less committed supporters and thus larger numbers, while less risky, may simply go unnoticed. For example, the recent Palm

\(^{88}\)“Health, social movements, and Australian immigration detention” (Essex, 2018a).

\(^{89}\)“Psychology and its response to major human rights abuses: The case of Australian immigration detention” (Essex, in press).
Sunday rallies across Australia were large but they failed to garner any significant media attention (Special Broadcasting Service [SBS] News, 2018). For those within detention, the social movements literature also helps transform the clinical to the political. Riots, self-harm and other acts of resistance such as hunger strikes should not be medicalised. Contentious politics provides a political context in which such acts can be recognised as resistance to a repressive system.

Social movement theory accounts not only for what social movements do, but how they do it and the factors that influence such action. The organisation of movements and the networks that surround them, including factors such as leadership and cohesion play a critical role in their success or failure. As Tarrow (2011, p. 16) notes, while there is no correct way to organise and network, if a movement is to be effective and contention sustained, it should be based on “dense social networks and effective connective structures”.

Whether action is successful or not depends on a range of external factors, some more controllable than others. The series of opportunities and threats that face challengers, and the government’s response, can influence the trajectory of a movement and whether it realises its demands.

Closely following this point, social movement theory does not assume people will behave rationally, and future action should be planned accordingly. Power, politics and emotion influence movements and those in power often more than any reasonable, rational argument.

In any social change, success is difficult to define and measure. Gamson (1990) defines success as the gradual advancement of objectives and argues that any measure of success should also include the acceptance of the movement in the national discourse and political circles or the attainment of new advantages for challengers. Thus action, in this respect, may be successful without achieving its stated objectives. Goal displacement has been used in the literature to describe why goals achieved may be less ambitious or even not reflect original aims. While there are a number of reasons for this that cannot be listed here, goal displacement is not just due to external factors. Many internal forces also shape what might be achieved. For example, strategies that mobilise participants paradoxically also serve to displace original objectives with less ambitious ones (Grodal & O'Mahony, 2017; Warner & Havens, 1968).
It is also important to take into account the limitations of social movement theory. Like many of the theories discussed throughout this thesis, careful consideration is still needed in regards to the social, political and historical factors that relate to Australian immigration detention.\(^{90}\)

Social movement theory offers no roadmap or concrete long-term solutions. Beyond the immediate to medium term, change is difficult to plan. This is because these theories cannot account for the innumerable variables and contextual factors that shape social movements and responses from challengers, many of which were discussed above. Social movement theory also makes us aware of the limitations and pitfalls of movements. With these limitations in mind, social movements should be flexible and responsive to dynamic external forces including political opportunities and threats. The limitations in planning a response to Australian immigration detention have been reflected in the writing of this thesis itself. Many updates and revisions have been necessary because of shifts in policy, and few would have imagined that the Border Force Act (2015) would pass with bi-partisan support.

Finally, social movement theory helps put things in perspective. Seen amongst other action that has pushed for equality and justice, such as the civil rights movement, feminist movements, the anti-apartheid struggle in South Africa, social change does happen, but often over long periods of time and in a nonlinear fashion.

6.6 What Action is Justified?

Social movement theory and many of the other theories introduced in Chapters 5 and 6 say little about what action is justified in response to Australian immigration detention. Not every social movement pursues just ends and many others utilise violent tactics. If we are to answer the question of how clinicians should respond, consideration also needs to be given to the type of action that may be justified. Given the call for a greater politicisation of action, including closer engagement with theory that incorporates more radical action, what action is justified in pursuing the standards outlined in Chapter 2; both within and outside of immigration detention?

\(^{90}\) Many of these were outlined in Chapter 1, when discussing Nethery’s (2010) thesis.
What action might be justified within immigration detention? While routine clinical care should remain largely uncontroversial, should clinicians engage in advocacy and subversion to achieve their ends and if so, how forceful should they be? Taking Briskman and Zion’s (2014, p. 279) definition, the case for advocacy as “a means for people to take action arising from their witnessing” is clear cut. Clinicians should report on human rights abuses, particularly when these would otherwise go unreported and particularly when there is no obvious opportunity for redress. Additionally the Australian public have a right to know the impact of these policies (Reilly et al., 2014). Without witnessing and whistle-blowing, little would be known about the conditions within detention. Many enquiries and protests feature testimony from clinicians who have worked within the immigration detention system (AHRC, 2014). Subversion should also be seen as a possible response. Subversion was defined in Chapter 3 as “dispensing acts of kindness that may not be valued or even prohibited by the employing or subcontracting authority” (Briskman & Zion, 2014, p. 279). This could involve anything from bending the rules or even taking subtle steps to undermine contractors and the Australian government’s power within detention. Such action should be seen as a potential means to protect the health, wellbeing and rights of those detained. Furthermore, support for both advocacy and subversion can be found in the standards outlined in Chapter 2 and more tacitly from professional healthcare bodies. How to pursue such action day to day depends on a range of contextual factors however. For example, in many cases advocacy and subversion may also do more harm than good. The general hostility toward advocacy was already outlined in Chapter 3, there would also likely be repercussions if the immigration department or security contractors became aware of subversive activity. Therefore, careful judgement is required as to what may be the most appropriate action in any given situation.

Should clinicians break the law? This will be discussed below with specific reference to the Border Force Act (2015). It is worthwhile noting here that there is limited legislative oversight in the day to day operation of detention centres. As was discussed in Chapter 1, The Migration Act (1958) contains little detail in relation to the conditions under which people are detained.

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91 Advocacy may also be prohibited, so it may not always clear cut what is considered advocacy and what is considered subversion.

92 While not explicitly endorsing such action, as was outlined above, almost all codes emphasise clinicians’ roles in upholding human rights and placing their patients’ interests above all others.
and how healthcare should be administered. The majority of the rules and procedures within centres thus come from the immigration department and other contractors. In most cases subversion and advocacy would not be illegal, and with the exception of the 15 months that the Border Force Act (2015) was in effect it was otherwise not illegal to discuss the conditions of detention or its impact. Regardless, disobeying policy or other rules and regulations will continue to carry risks; the above caveats continue to apply.

6.6.2 Social and Political Action

In previous chapters I argued that both clinicians and professional bodies should reconceptualise how they approach Australian immigration detention, this includes engaging with theory that incorporates contentious and adversarial political action. What action is justified outside of detention settings?\(^{93}\)

Some action will be uncontroversial and should continue. This includes advocacy, research, lobbying and protest. Violence should be ruled out. It carries far too many risks, is likely to be repressed easily and is likely to do more harm than good. A more difficult question however is whether clinicians should engage in civil disobedience.

Civil disobedience for these purposes could be defined as a nonviolent, public and conscientious breach of the law, undertaken with the aim of bringing about social and political change (Rawls, 2009). In responding to Australian immigration detention such action can be justified and should be used in limited circumstances by clinicians and supported by professional bodies. The justification for such action comes from the recognition that Australia’s laws and policies in relation to refugees and asylum seekers are excessively unjust. As was discussed above, Australia’s approach is exceptional: it systematically and deliberately violates human rights and inflicts suffering with the aim of deterring asylum seekers from travelling to Australia by boat. This of course alone would not justify civil disobedience, particularly if there were more straightforward ways to remedy these policies, however this is often not the case.

\(^{93}\) This discussion could not be exhaustive regarding the “type” of action, as I will argue in Chapter 7. However I hope this begins to outline a broad spectrum of action that is justified.
Additionally, there is also a precedent for such action. Professional healthcare bodies have previously supported acts of civil disobedience. For example, clinicians who continued to speak out after the introduction of the Border Force Act (2015) were engaging in civil disobedience (Safi & Farrell, 2015). It should be noted however that other contentious and relatively impactful action, such as the case of Baby Asha and other whistleblowing, while disruptive, have not necessarily reached this threshold and broken the law.

6.7 Why Clinicians and Professional Bodies Should Act

“Everyone has duties to the community in which alone the free and full development of his personality is possible” (UN General Assembly, 1948, art. 29).

What business do clinicians have in politics and why should their role extend beyond that of more orthodox clinical care? The obligation to both uphold human rights and to advance the health and wellbeing of refugees and asylum seekers should be seen as being role obligations (Hardimon, 1994). That is, a “moral requirement, which attaches to an institutional role, whose content is fixed by the function of the role, and whose normative force flows from the role” (Hardimon, 1994, p. 334). The fact that clinicians who have worked within immigration detention and are implicated in its harms only re-enforces this responsibility.

This obligation is further re-enforced by human rights instruments (UN General Assembly, 1948) and guidelines from professional healthcare bodies that outline duties, including the promotion and protection of human rights (AMA, 2015; APS, 2011; RACP, 2015). This obligation however extends beyond the traditional clinical sphere into the social and political. Furthermore it goes beyond advocacy and the dissemination of information to engaging in movement based action including protest, disruption and in limited cases, non-violent civil disobedience. Why should clinicians take such action?

First, clinicians are unlikely to be able to fulfil their obligations working within the system. This was discussed in Chapters 2 and 3. Furthermore, health, wellbeing and human rights cannot be separated in this context; that is, health can only be realised through human rights and human rights through health (Halonen, Jilani, Gilmore, & Bustreo, 2017; World Health Organization, 2017). Where they are unable to address health, wellbeing and human rights
within their normal clinical capacity, clinicians have a duty to take further action. Utilising public health ethics, McNeill (2003, p. 500) outlined and justified the case for such action almost 15 years ago:

The case for political action is well established. What is not clear is the kind of political action that might be both justified and effective. The commentators are agreed that disseminating information and advocacy are legitimate activities in public health. The difficulty is when neither seems sufficient. In Australia, the Prime Minister and Minister of Immigration have been unresponsive to information that revealed the harmful effects of their policies. They appeared to be immune even to extreme accounts of human suffering. Advocacy may not be sufficient to influence a Government that is willing to resort to the harshest of measures in dealing with the most vulnerable of people.

This leads to the second reason, social movement theory and other theories of social change have a greater chance of being effective in pursuing the ends outlined in Chapter 2 than current approaches to these issues. I made the case for this in Chapters 5 and 6

Third, the circumstances related to Australian immigration detention are exceptional. The government is unresponsive to traditional forms of advocacy, information and research. Those detained are amongst the most vulnerable and face ongoing violation of their rights. These human rights breaches are multiple, systemic and deliberate. As was discussed above, over 80% of Paediatricians considered immigration detention to be a form of child abuse (Corbett et al., 2014). Routine care is completely inadequate.

Fourth, those detained are vulnerable, not just in regards to their health status, but because they cannot seek redress themselves. They are lacking what Arendt (1958, p. 296) recognised as the precursor to all other human rights, that is, “a place in the world which makes opinions significant and actions effective”. Hall et al. (2018, p. 49) introduces the concept of “belonging by proxy”, that is “citizens protesting in their own name but also on behalf of those not given the right to settle in Australia”. Recognising that it may not always be in the best interests of asylum seekers and refugees to participate in protest, belonging by proxy “demonstrates solidarity between those privileged with the safety of residency and citizenship who can express their concerns and dissent, and those absent from the rallies precisely because they are denied those
rights” (Hall et al., 2018, p. 49). The need for action from others and particularly those who have worked in close proximity to the system is thus not only important but also necessary.

Finally, there is a historical precedent for such action. Professional healthcare bodies have all called for the reform of Australian immigration detention. Through guidelines and position statements they have supported clinicians advocating and reporting on the health and wellbeing of those detained, even when this became illegal under the Border Force Act (2015). They have supported whistle-blowers (Laughland & Davey, 2014; Owler, 2016) and protest against increasingly regressive policy (Berger, 2016; Safi & Farrell, 2015). Professional bodies have also supported clinicians in their decision making, including in the case of Baby Asha, discussed throughout this thesis.

Politicising action and shifting focus from individual clinicians also implicates professional healthcare bodies. They have similar obligations. For a long time they have called for reform of Australian immigration detention and made public the damage it does. They have supported protesters and whistle-blowers and have called for the government to honour its human rights obligations. These obligations extend beyond supporting clinicians who speak out publicly, or supporting protests. Professional healthcare bodies have an obligation to lead in this area, and engage more actively with the messy political realities of both within and outside of detention.

6.8 Conclusions

Social movement theory and other theories of social change, such as Subašić et al.’s (2008) model of political solidarity provide a platform to better inform future action and pursue the standards outlined in Chapter 2. Above I outlined how these theories could be applied to better understand and plan responses to Australian immigration detention. I also outlined the type of action that is justified and why clinicians should act; not only engaging in more familiar forms of action but also considering contentious and adversarial action as part of their repertoire. Throughout the chapter I outlined why engaging with these theories provide a more effective basis on which to take action than previous responses to these problems. These theories have the potential to inform the systemic (Zion, 2013) and political change (Koutroulis, 2003) that has long been called for. They provides strategy for protest (Berger, 2016; Isaacs, 2015c) and a repertoire of action, that moves beyond frustratingly ineffective advocacy and research.
(McNeill, 2003). More practically, what action could this approach entail? In Chapter 7 I will draw together insights from the above theories and from throughout this thesis to discuss a number of directions for future research and action.
Chapter 7  How Clinicians and Professional Bodies Should Respond to Australian Immigration Detention

7.1  Overview

How should clinicians and professional bodies respond to Australian immigration detention? This chapter will draw upon previous chapters to more completely answer this question. I will first summarise this thesis and then deal with limitations and potential objections, clarifying what I see to be some of the shortcomings and possible points of contention. I will then discuss directions for future research and action. These recommendations draw on many of the insights discussed throughout this thesis; opportunities that exist in current policy and legislation, the standards outlined in Chapter 2, lessons learnt from current approaches and how Subašić et al.’s (2008) model of political solidarity and social movement theory inform action.

7.2  Summary of Thesis

Australian immigration detention deliberately inflicts harm and violates human rights and international law. Because it is a form of administrative detention, it gives the Australian government substantial powers and leaves limited scope for legal redress. This power has largely gone unchallenged politically with both major parties supporting an approach based on deterrence. Those who have criticised these policies have been frequently attacked by successive Australian governments that have resolutely maintained these policies.

In Chapter 2 I argued that Australia should, at a minimum, do what it has committed to do internationally. That is, it should pursue policies that are consistent with international law and human rights. The standards outlined in Chapter 2 are based on the recognition that human rights are a prior requirement for health and that human rights cannot be upheld within detention. So while health and healthcare within detention remain important, health and wellbeing will not be significantly improved without broader systemic, social and political change.
The deficiencies related to healthcare within immigration detention have been documented for over two decades. Despite protest and calls for reform, little has changed. In Chapter 3 I outlined the healthcare arrangements within detention. I discussed what has been said by professional healthcare bodies and in the research literature. I also critiqued current responses to health and healthcare within Australian immigration detention. I argued that despite the longstanding recognition in position statements and the literature of the need for reform, the concepts they use and the guidance they offer are evidently ineffective in bringing about such change. I advance two related but distinct arguments that outline why this is the case. First, present approaches overly depoliticise and individualise health, healthcare and the resolution of dilemmas within immigration detention. Second, despite over two decades of protest, current concepts and guidance offer little strategy in relation to broader reform and social change.

Chapter 4 argues that despite these shortcomings clinicians should not boycott working in detention. I argued that even though a boycott is appealing under current circumstances, the potential harm it could do to detainees is reason enough to be cautious. In addition to this, a boycott appears very unlikely in the foreseeable future and therefore future action should plan accordingly.

Rejecting a boycott does not mean accepting the status quo, however. Chapter 5 outlined a new approach toward health and healthcare in Australian immigration detention. I called for two shifts. The first is a greater politicisation of health and healthcare in relation to Australian immigration detention. This means a greater acknowledgement of the trade-offs that come with working within the system. More importantly, acknowledging these limitations entails a greater focus on justice and rights rather than the day to day clinical issues. Second, and related to this point, an expansion in the roles that clinicians and professional bodies have outside of detention. I introduced a number of theories that support this approach and importantly better position future action to pursue systemic, social and political change.

Chapter 6 outlined and applied Subašić et al.’s (2008) model of political solidarity and Tarrow’s (2011) framework of contentious politics, both introduced in Chapter 5. I provided an outline of each of these theories, while also showing how they offer a more sophisticated means to explain and to guide future action. I concluded by arguing that clinicians and professional bodies have a responsibility to act, employing forms of political action such as disruption and civil disobedience.
In the remainder of this chapter I will first discuss some potential limitations and objections to the approach proposed above. I will then begin to outline some more practical steps for action and research, based on the insights on discussed throughout this thesis; opportunities that exist in current policy and legislation, lessons learnt from current approaches and how Subašić et al.’s (2008) model of political solidarity and social movement theory inform action. While I will attempt to link these recommendations with the standards outlined in Chapter 2 this is not always possible. While some action will be more relevant in targeting specific standards, most will be aimed at more general reform, often involving collaboration and cooperation with a number other parties.

### 7.3 Limitations, Clarifications and Potential Objections

The approach I called for throughout this thesis that is not without its shortcomings. Some of these have been identified in earlier chapters, others have yet to be discussed. This section tackles the main limitations and potential objections.

First, the type of reform I am calling for could lead to more deaths at sea, and the government implementing increasingly harsh policy as a result. I explicitly called for a regional approach that was consistent with human rights and international law, and why I have done so is worth clarifying. As I said above, health and healthcare cannot be divorced from broader policy reform, and such reform is likely to have regional implications. It is possible that people will again begin to travel to Australia by boat, and thus risk their lives at sea. This is another reason why healthcare cannot be thought of in isolation and why broad objectives have been proposed. Reform need not lead to further deaths at sea, however. The government has advanced the argument that not only are current policies necessary to save lives, but they are in fact the only way to do so. This is a false claim, and it is undermined by the Australian government’s regional approach, which was outlined in Chapter 1. There are other options for a regional framework, which will be discussed below.

Second, my rejection of a boycott appears inconsistent with calling for more disruptive action to be embraced. While I agree that a boycott would be disruptive and create significant contention, such action would also likely result in harm to those detained. Additionally, and as
I will discuss below, there are seemingly endless possibilities in pursuing more contentious and disruptive action. However the opportunities such action present, need to be balanced against the risks, as was discussed in Chapter 6. As I will argue below, a boycott should remain in any repertoire of future action and be pursued if the risks of taking such action can be minimised, especially the impact it could have on detained refugees and asylum seekers.

Finally, this thesis focuses largely on clinicians’ roles outside of detention, while also rejecting a boycott. Thus clinicians will continue to work within immigration detention and the research question of what they should do remains partially unanswered. Most importantly and as I argued in Chapter 2, the standards outlined are based on the recognition that health is dependent on human rights first being upheld and that human rights cannot be upheld within detention. Thus, focusing on clinicians’ roles in immigration detention would have likely contributed little to both theory and practice and most importantly, the health and wellbeing of those detained. For example, even if clinicians can be better supported, even if they can better reconcile some of the dilemmas they face (which seems unlikely), this may only result in marginally better care for those detained and fail to address the multiple and ongoing human rights abuses. The literatures dealing with social change I introduced have received little attention from the healthcare community. They provide a platform for political action and are well placed to begin to address the well-recognised need for systemic, social and political change. Finally, while it has not been a focus of this thesis, I will discuss the roles of clinicians within detention below, along with what I see to be important reforms for healthcare.

7.4 Directions for Future Research

“The need for strong policy research that is prepared to speak truth to power rather than about it has arguably never been greater” (Hunter, 2015, p. 2).

Further research is needed. First, there is a need for research that asks why Australian immigration detention persists and why Australia is leading the western world in cruelty toward asylum seekers and refugees. This was discussed in Chapter 1 when outlining Nethery’s (2010) thesis. Surprisingly, since this thesis was written, there has been little research that has dealt with the issue of why Australia does what it does with such sophistication or in such a
comprehensive manner. Australian immigration detention is a complex and enduring problem, the greater depth of understanding we have, the better positioned we are to respond.

Second there is a need for greater engagement with the social movements literature and other literatures on social change, such as Subašić et al.’s (2008) model of political solidarity. This could focus on any number of areas, from the actions challengers have utilised, to how they have exploited opportunities and dealt with threats. How movements have effectively utilised emotion and framed these issues appears to be a particularly fruitful area. This research should focus not only on how to combat government rhetoric, but also on how to proactively make meaning. The Asylum Seeker Resource Centre (2017) “Words that Work” study is one example of such research (Shenker-Osorio, 2015). Further research could apply and examine Subašić et al.’s (2008) model of political solidarity, exploring values, norms and beliefs not only in relation to asylum seekers and refugees, but toward those in power in Australian and how these could shifted.

Understanding past action through the lens of social movement theory provides a foundation on which future action can be understood. Research needs to take stock of the successes and shortcomings of action. What made a particular action effective? What were its shortcomings? Was it counter-productive, and if so, what can be learnt from this? Social movement theory could be used in a number of ways to begin to answer these questions. Jackson (2018) for example employs social movement theory in a comparative study examining the actions of clinicians in attempting to restore access to healthcare for asylum seekers in Canada, England and Germany. Examining the different outcomes of each of these movements, this approach allowed for the comparison of the conditions under which governments could successfully restrict healthcare for asylum seekers and the conditions which supported clinicians in attempting to reverse these changes. Similar studies are needed to examine the Australian context. There is also scope to utilise social movement theory to explain particular episodes of contention and campaigns in detail, for example the #LetThemStay campaign (Hall et al., 2018). There is substantial scope to expand this work and explore other episodes of contention. Take the outstanding questions and future directions proposed by Hall et al. (2018, p. 52) in examining the #LetTheyStay campaign:

First, more in-depth exploration could uncover how maintaining momentum in the media on a particular issue can lead to positive outcomes, while also reflecting on what happens
more generally after protests on a particular topic end and media attention turns to another issue. Second, future research could explore the role of images used in the media to support the cause of protesters, and how the diversity of protesters depicted impact such portrayals... Third, we noted that acts of civil disobedience (such as churches offering safe havens, and doctors refusing to release Baby Asha) and creative campaigning methods (such as the cribs installation on Bondi Beach) were used as part of the #LetThemStay campaign; future research could consider how these forms of protest impact public opinion and policy outcomes, and how they relate to more visible forms of protests like rallies. Fourth, an interesting aspect that deserves more attention is how focusing on a particular group of people, or a particular aspect of contentious issues can actually undermine the potential for broader policy impact and social change ... Finally, it would also be essential to research the potential impact protests can have on shifting policy directions and on public opinion on refugees and asylum seekers specifically in much more depth using mixed-methods approaches.

Finally, research exploring and documenting the experiences of those in detention should continue. This includes both clinicians and those detained. While this thesis called for a shift in how clinicians respond to Australian immigration detention, research within detention remains important for a number of reasons. First, research is an integral part of the culture of healthcare institutions, and it is therefore natural for health care professionals to pursue these concerns through research into the ethical conditions of their own practice. Second, such research will continue to provide important information about how states are able to co-opt health care institutions and professions into activities which target vulnerable populations for purposes that are antithetical to their health, wellbeing, long-term security and human rights. Third, immigration detention is effectively a “total institution”—that is, one which isolates a particular population and exercises control over every aspect of their lives. Unsurprisingly, settings like this are likely to facilitate abuses of power, so there is a strong case for research to provide a degree of external oversight in this particular setting. Finally, there may well come a time when the Australian government is legally held to account for its policy of mandatory detention and for the death and human misery it has caused. If and when that time comes, findings of research that has been conducted by and/or with practitioners who have first-hand experience of the system could provide important evidence (Essex & Jordens, 2018).
While the importance of collaboration more generally will be discussed below, it will also be important for future research. The research discussed above spans a range of literatures and expertise, while the healthcare community should be a driver of such research, collaboration will be essential. Academics, lawyers and those detained all should be closely involved and where possible a greater diversity of expertise and opinion utilised.

7.5 Directions for Future Action

There are a number of reasons why it is difficult to be prescriptive in relation to future action. Some of these reasons were discussed in Chapter 6, they are worth repeating here. First, the dynamic and largely relational nature of action makes any strategy beyond the immediate to medium term difficult to formulate. Recall in Chapter 6 that the outcome of contentious action cannot be predicted by examining what a single movement does at a single point in time. Challengers must be seen in relation to those in power, their allies and, more generally, the context in which they operate. Second, there are simply too many different types of action that could be employed. For example, Sharp and Finkelstein (1973) identify over 180 different types of non-violent action. With these caveats in mind this section will begin to identify directions for future action. This section has been informed by all areas of this thesis, drawing together various insights from the existing and newly introduced literatures. While some recommendations are less prescriptive than others (for the above reasons), this section will largely focus on areas where clinicians and professional bodies may have particular impact in utilising their skills, knowledge and relative power to pursue change. While I will attempt to introduce ideas that begin to address the systemic, social and political change I have called for throughout this thesis, I will also discuss important reform within Australian immigration detention. As noted earlier, while attempts to improve healthcare within detention will be vexed, this does not mean that such attempts should be abandoned.

I will focus on six areas below: 1) revisiting what should be done in relation to a boycott; 2) future directions for those working in detention; 3) future directions in social and political action; 4) collaboration and cooperation with others; 5) how clinicians and professional bodies should contribute to the reform of Australia’s regional approach, and 6) how clinicians and professional should contribute to promoting international pressure on the Australian government.
7.5.1 Boycotting Australian Immigration Detention

As was discussed in Chapter 4, changing circumstances within immigration detention centres would change the ethical and practical considerations that need to be factored into a decision about whether to proceed with a boycott. Discussions in relation to a boycott should thus be ongoing. What does appear likely to happen in the future is that those offshore are likely to be resettled, although this may take some time (Daniel, 2017). When this time comes, a boycott should again be seriously considered. A boycott under these circumstances would not impact detainees. By the same token, nor would it disrupt the government. It would therefore have only symbolic value.

Furthermore, clinicians and professional bodies should seriously consider refusing to undertake particular aspects of their role. The government has long utilised clinical skill to achieve its ends. Some of the ways this has been done were discussed in Chapter 3. There are a number of activities that clearly have limited therapeutic value. Explicit guidance is needed on activities such as health assessments in forced deportations. While clinicians should refuse to participate in these practices, this may not always be feasible, or on balance, in the best interests of those detained. Additionally for such action to be impactful, it would need to be collective. Thus professional bodies should make their position clear on such practices.

A boycott in other forms should also be considered—for example, boycotting IHMS. Chapter 3 introduced the relatively effective “No Business in Abuse” campaign. Similar action should be considered. While IHMS is a private company, pressure could still be applied by promoting its involvement in Australian immigration detention and the multiple well-documented failures of care. IHMS is a subsidiary company of International SOS (Farrell, 2015b) and although privately owned, a campaign to highlight this connection and rally clients of International SOS could also be impactful.

94 Such action may not be considered a “boycott” in the traditional sense, it is however useful to think of them in this context, that is, the withdrawal of services with demands for change attached.
7.5.2 Working within Immigration Detention

I will focus on three areas below: the changes that should be made to existing codes and guidelines; steps to increase oversight and accountability within detention, and the steps that should be taken to facilitate detainees speaking out. Any response while working within detention is likely to be most relevant to standards 1 and 7 that were outlined in Chapter 2. Namely, the right to health and the conditions of detention. The importance of clinicians continuing to work in detention will be considered in the next section, particularly their roles in whistleblowing and making their experiences of working in detention public.

7.5.2.1 Codes, Guidelines and Position Statements

Position statements should acknowledge the explicitly political nature of working in immigration detention. They should reflect the well documented limitations in delivering healthcare, while also better acknowledging the complex and conflicting nature of working within immigration detention. To this point, the RACP (2015) has come closest to doing this. Clinicians will continue to face multiple conflicts for which they will have to make complex decisions for which there is no formula. Advocating, negotiating and reconciling dilemmas will be necessary, not just in relation to those detained but between a range of other stakeholders, all of whom have divergent interests. Such dilemmas will remain. This thesis offers no remedy for these, however a conversation as to how best to respond cannot begin while many professional bodies continue to call for the impossible or deny any conflict exists.

That said, clinicians should try to provide the highest standard of care possible in the circumstances. This care will not meet a standard equivalent to that found in the broader Australian community, however. At a minimum, clinicians should act to minimise their involvement with the particularly harmful elements of the system and avoid creating additional dilemmas in the longer term. Thus, in some cases it may be appropriate to abide by the restrictions put forth by centre management. In other cases it might be more appropriate to advocate for those detained, or act subversively when it presents minimal risk and there is likely to be few repercussions. While clinicians cannot necessarily influence decisions on the release of refugees and asylum seekers, they may be able to take steps to alleviate some of the stressors associated with detention. This could include addressing issues related to accommodation or
administrative restrictions within centres. In many cases more orthodox clinical intervention may not be warranted or even desirable.

Guidance that focuses on the clinical recommendations should be applied with caution, and broader systemic forces better recognised. There should also be greater engagement with concepts such as the humanitarian border (discussed in Chapter 5) and the public health ethics literature. This will assist in shifting the focus to the detention system and the broader social and political factors that are perpetuating harm. For many this will involve embracing action which might be unfamiliar in more orthodox clinical settings.

Finally, position statements should include many of the recommendations below. First, mandatory reporting human rights abuses should be encouraged. Like mandatory reporting of child abuse, professional bodies should also take steps to ensure clinicians report human rights abuses and take cases to the media where appropriate. Second, ongoing supervision should be offered to clinicians who continue to work in detention centres. Such an initiative would overcome the largely static nature of position statements that have been unable to account for the complexities of healthcare in immigration detention, allowing clinicians to discuss complex ethical and clinical questions with colleagues. Third, position statements should promote clinicians’ roles in social and political change as has been done throughout this thesis. The APS Position Statement (2011) is currently the only one that comes close to doing this. Position statements should acknowledge that human rights cannot be protected or advanced while working within detention. Human rights must be actively protected and fought for by opposing repressive and discriminatory policies. There should be explicit support for action such as protest and non-violent civil disobedience for this reason. And finally, there is strength in numbers. Major healthcare bodies should therefore put out a joint statement to this effect.

7.5.2.2 Supervision, Oversight and Accountability

There have been a number of missed opportunities for improving oversight and accountability within immigration detention. These opportunities are not informed by any particular theoretical perspective95, but have simply been overlooked or inadequately communicated.

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95 It could however be described as an opportunity utilising social movement theory.
As was outlined in Chapter 1, The Migration Act (1958) contains little about how Australian immigration detention should be run or the conditions within detention. The operation of centres along with policy and procedures is dictated by the immigration department and contractors. Thus (except when the Border Force Act was in effect) practical steps to increase transparency and accountability would not be illegal. Professional bodies should seize this opportunity to set up channels for greater communication for those working within immigration detention. This could be as simple as a telephone or online service which offers mandatory (or highly recommended) supervision. Clinicians working in detention would converse regularly with their peers. This would serve a number of functions in addition to providing clinical guidance and supervision. Such initiatives would also increase oversight and accountability, going part of the way to addressing issues of isolation and allowing an avenue to report human rights abuses. Creating channels for advocacy and for reporting abuse could also hold those responsible to account.

Finally, in further bolstering transparency and accountability, professional healthcare bodies should consider their role in handling complaints or cases of inadequate care, particularly in offshore centres. While transparency and accountability remain an issue onshore, detainees have access to services provided by the Healthcare Complaints Commission (HCCC) and the Commonwealth Ombudsman. Those offshore have few legal protections. Doctors4Refugees have already started taking such action. Professional bodies should consider their role in doing the same or supporting existing efforts.

7.5.2.3 Refugee Voices and Protest

Clinicians and professional bodies should also play a role in helping those detained speak out. This could be done by utilising the means proposed above or could be as simple as providing access to a mobile phone. There is a growing literature in this area (Ataç et al., 2016). Such action provides a political voice to those otherwise considered “marginal, vulnerable, and politically voiceless or invisible” (Ataç et al., 2016, p. 532) providing a means to temporarily “escape regimes of control through movement and political motilities” (Ataç et al., 2016, p. 535).
There are already numerous examples of detainees speaking out, for example projects and organisations such as Behind the Wire\textsuperscript{96}, RISE: Refugees, Survivors and Ex-detainees and The Refugee Art Project\textsuperscript{97}. Since Manus Island was re-opened those detained have had a growing presence in the media, both in Australia and internationally. Behrooz Boochani, an asylum seeker and journalist who was detained in the centre, has gained increasing attention, and provided a powerful account of the experience of detention, writing and leading peaceful protests (Boochani, 2016). There is a greater role for clinicians and professional bodies to play (particularly because they work in such close proximity) to facilitate greater communication between those detained and the Australian public.

Clinicians and professional bodies should also acknowledge the legitimate role of non-violent protest and disobedience for those who are detained\textsuperscript{98}. While in some cases it may be counterproductive to facilitate or openly support such action, it could also provide opportunity to stand in solidarity with those detained.

7.5.3 Social and Political Action

Outside of detention, how should clinicians act? This section will be informed by the literatures discussed in Chapters 5 and 6 and will contain a range of recommendations and insights for future action. I will focus on seven related issues that I see as being particularly important given the lessons that can be taken from earlier chapters: (1) Drawing on political theory to inform future campaigns, (2) framing grievances and responses to Australian immigration detention, (3) utilising the media and the importance of the testimony of former employees, (4) the promotion of alternatives to detention, (5) engaging in disruption and civil disobedience, (6) the reform of external healthcare services, and (7) acting on opportunities and threats. This is not an exhaustive list nor will some of these activities only involve clinicians. I have however attempted to focus on areas which appear to be particularly important or under addressed and where clinicians expertise could be particularly well utilised.

\begin{itemize}
  \item \textsuperscript{96} http://behindthewire.org.au
  \item \textsuperscript{97} https://facebook.com/TheRefugeeArtProject
  \item \textsuperscript{98} Similar to Briskman & Zion’s (2014) idea of clinicians acting subversively, clinicians should also acknowledge the legitimacy of those detained acting subversively.
\end{itemize}
Campaigns that have attempted to build solidarity and gain greater public support for refugees and asylum seekers have largely been atheoretical. They have also had limited impact in combatting the government’s narrative. Future action could be more effective if informed by theory. Subašić et al.’s (2008) framework provides a starting point for this. This framework suggests that if future action is to be successful people not only need to identify increasingly with refugees and asylum seekers but also increasingly de-identify with the government. There is substantial scope for further research in this area, however some starting points could include challenging the need for immigration detention on national security or “humanitarian” grounds while also emphasising traditional Australia values and mythology such as freedom and fairness (Shenker-Osorio, 2015). Action also need not be contained, disruptive action should also be considered in building solidarity. While this might seem counterintuitive, more disruptive forms of action stand to challenge government legitimacy, that is, acting deliberately in an “un-Australian” and “uncivil” manner highlight the illegitimacy of Australia’s approach (Goodman, 2009).

There are some practical strategies which are low risk and easy to employ, and which should be pursued. One involves simple shifts in language. The Asylum Seeker Resource Centre (2017) “Words that Work” study (discussed above) analysed language that was most likely to shift beliefs in relation to asylum seekers. Three groups were identified, those who already supported asylum seekers and refugees, those who opposed them (and would not change their minds) and those who were persuadable. The research shows what language is most effective in persuading the bulk of Australians to shift their ideas on people seeking asylum. Some of the key findings include appealing to values such as “family, freedom, fairness and treating others as you’d want to be treated” or appealing to “Australian mythology and self-perception”99 (Shenker-Osorio, 2015, p. 11) and directly acknowledging that Australia’s policy of mandatory immigration detention is harmful. A further recommendation of this relates to providing solutions to these issues, not just highlighting shortcomings, something that will be discussed in the next section.

How language is employed relates closely to how issues and responses to Australian immigration detention are framed, discussed in Chapter 6. Clinicians and professional bodies

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99 The tension in framing these issues in this way was discussed in Chapter 6. This remains something any future action should be mindful of, it should also however not impede empirically supported approaches to these issues.
should carefully consider how they frame their grievances. While I have called for a greater politicisation of action in this thesis, the most effective way to frame issues is often to act in an apolitical way. That is, simply making the case that clinicians are unable to do their job. This was discussed in Chapter 6, when exploring the case of Baby Asha and during protests against the Border Force Act (2015). This message could be amplified through united action from professional bodies, first acknowledging this in position statements while also challenging government claims, such as healthcare being provided to an equivalent standard to that found in the Australian community. Employing such rhetoric is also not necessarily in conflict with my call for a greater politicisation of action. Such rhetoric should however remain cognisant of the broader political context in which it is used.

The media has played a role in amplifying such messages and has also been used to highlight cases of inadequate treatment or abuse. This should continue. The case of Baby Asha and cases promoted by Doctors4Refugees (discussed in Chapter 6) have both shown how the media may be used as an effective tool to amplify contention and bring attention to cases of substandard care. The media has been utilised to circumvent the government’s attempts to silence clinicians and those detained, it has also been used to leverage clinicians’ already relatively powerful positions (albeit in a disempowering system). Those who work within immigration detention should carefully consider utilising the media in cases where other reasonable requests have failed. The more general importance of framing and working with the media is best summarised by Durham, Brolan, Lui, and Whittaker (2016, p. 18):

While coalitions with partners in health are important, non-traditional or non-health alliances are essential to presenting common messages and changing public opinion in order to secure policy change. This must include working with a range of media to change the current discourse and social construction of people who seek asylum. People who seek asylum are not acting against the law and they are not “illegal immigrants” or “queue jumpers”. Rather, they are people fleeing insecurity and persecution, often religious or other persecution, often at the hands of their own governments, and who are exercising their right to protection—a right that Australia has pledged to honour. Research suggests that refugees contribute significantly to host societies bringing needed skills, services and entrepreneurship and demand for host country products, and we need to promote these positive stories and address the fears of those who have discriminatory attitudes toward asylum seekers. A sustained and coordinated effort to
redefining the problem is critical in changing community opinion and providing a policy window for change.

Action which has been relatively impactful in the past has often come from clinicians who have worked within or in close proximity to the system. The case of Baby Asha, the protests in response to the Border Force Act (2015) and numerous other clinicians whistleblowing or bringing to light their experiences (see Chapters 1 and 3) have all had a significant impact. Clinicians who have worked in detention have a particular responsibility to write, speak, testify or simply share their stories. What can be learnt from the contentious action discussed above is that clinicians who have worked within immigration detention have a degree of authority on these issues. The government has rarely attacked individual clinicians or professional healthcare bodies. Additionally, it has also been those who work within or in close proximity to the system that have been able to exploit opportunities, as outlined in Chapter 6.

Alternatives to detention should also be promoted. This moves current responses forward from being simply reactive and also serves to challenge the government’s narrative that deterrence is the only way to prevent asylum seekers drowning at sea. There are a number of organisations already dedicated to doing this. The International Detention Coalition (2017) “aims to bring about changes in legislation, policy and practice that prevent, mitigate and respond to the harms associated with immigration detention and that promote alternatives to detention”. The Global Detention Project (2017) similarly aims to “improve transparency in the treatment of detainees… encourage adherence to fundamental norms… reinforce advocacy aimed at reforming detention practices… promote scholarship and comparative analysis of immigration control regimes”. These organisations provide a range of research and policy documents, most of which is largely aimed at promoting better conditions or promoting alternatives to detention. This work has also been bolstered by other research and reports, for example the UNHCR Beyond Detention Report (2014).

Disruption (and civil disobedience) can have any number of targets. It could target the government directly or the operation of immigration detention centres for example. As was discussed earlier, whether action will be effective will depend on the action itself and the risks and opportunities that are present. Disruption can be shut down quickly. For example, while grabbing headlines from sympathetic journalists, those blocking the driveway of detention centres to stop deportations are often quickly dealt with by the police. Clinicians who engage
in disruption as was the case with Baby Asha or civil disobedience, as was the case with those who spoke out about the Border Force Act (2015), have been most effective when using the opportunities or authority that come with their position. That is, the social status that comes with being a doctor, nurse or psychologist. Thus, rather than more general disruption, clinicians should look for opportunities where they could apply (or withdraw) their skills and use their position to disrupt the system.

The case of Baby Asha highlights a further opportunity for external healthcare providers to take greater action. Hospitals and clinicians external to immigration detention have significantly more leverage than those who work within the system. Even though it appears the government is now sending people to third countries for treatment (Doherty & Vasefi, 2018) (discussed in Chapter 6), those who work externally with asylum seekers and refugees should review their procedures, particularly in relation to discharge and advocacy. Clear guidelines for clinicians should be enacted across hospitals and healthcare facilities. Working externally to the system does not exempt clinicians or healthcare organisations from these obligations and to discharge children of families into danger is negligent.

A final point relates to opportunities and threats. Different opportunities and threats will present at different times for different people. Past action suggests that it is often those working within or in close proximity to immigration detention that have exposed political opportunities. This is a further reason to encourage greater communication between clinicians and particularly those working within detention. Finally, and as I discussed in Chapter 6, opportunities and threats can be difficult to predict, however every polity varies in what action is forbidden, permitted, or facilitated. The Australian government’s sensitivity to criticism and attempts to cover up the conditions within detention centres often ensures action that would normally be contained, becomes contentious. This presents both an opportunity and a threat. On the one hand it may be easy to have an impact, with action that would otherwise be relatively benign under other circumstances. On the other, this sensitivity has often led to the government acting quickly to shut down potential contention, for example by opening the gates of detention centres in order to fend off a legal challenge (Hurst, 2015a) or passing legislation to silence critics (Newhouse, 2015).
7.5.4 Organisation, Collaboration and Cooperation

How should clinicians organise, collaborate and cooperate both within their respective professions (or as a healthcare community as a whole) and with other professions?

Greater leadership is needed from professional healthcare bodies. This has been recognised by a number of other authors and clinicians (Sanggaran et al., 2014). Simply providing strongly worded media and position statements that call for change is not enough (Sanggaran & Zion, 2015). Groups that have solely focused on these (i.e., Doctors4Refugees) issues have provided a far stronger position for action and advocacy.

There is also a need for greater collaboration and cooperation with other professions and organisations outside the healthcare community. Academics, lawyers, teachers, human rights organisation, unions, artists, activists and concerned citizens have all engaged in action that has aimed to change Australia’s policies. Some of these have also had a significant impact (e.g., The No Business in Abuse campaign). Organisations such as GetUp! have already proven effective in advocacy and activism. Greater collaboration would allow clinicians to utilise existing expertise and networks, with action reaching a broader audience and being more impactful. Such organisations could also be used to communicate political opportunities. Greer et al. (2017, p. 42) provide advice on cooperation and collaboration more generally:

… political strategies are always context dependent, which makes it hard to give general advice. But there are a few points that apply in most systems. First, respect political professionals such as lobbyists, staffers, civil servants and politicians themselves. Politics is a full time job, their expertise in politics is crucial, and amateur policy making works about as well as amateur epidemiology. The most effective advocates know and can work with scholars and vice versa. So do not define the problem of having influence as that of starting a second political career. Define the problem as working with people who are political specialists and can help. Likewise, it is possible to engage in politics almost everywhere without becoming a party activist. Second, make use of resources that are already available such as university press offices. Third, skills such as effective use of social media, organizing techniques, testifying before legislators and input into

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100 https://www.getup.org.au
public consultations are not difficult to acquire, and public health organizations should be eager to help. And finally, persist. Advocacy, policy, and politics all have ample doses of frustration as well as luck. Only those who are around at the moment can seize the moment to do good.

7.5.5 Regional Reform

Any future action needs to be cognisant of its impact on the Asia Pacific region. As was discussed above health and healthcare cannot be divorced from broader policy reform and such reform is likely to have regional implications. With policy change it is possible that people will again begin to travel to Australia by boat, and thereby risk their lives at sea.

Fortunately, a number of reports have already proposed alternative regional arrangements that are consistent with human rights and international law. The Beyond the Boats report (B. Douglas et al., 2014) emerged from a discussion paper and an expert roundtable on refugees in July 2014. The roundtable sought to address two major issues: The approach toward asylum seeker and refugee boat arrivals who were already in Australia (including in the community), Nauru and Manus Island and Australia’s approach toward future arrivals and thus a long term policy. Recommendations from this report included expanding Australia’s humanitarian intake, ensuring fair and transparency processing, speeding up processing from source countries where there is need, ending mandatory detention and finding durable solutions for those detained offshore, developing a sustainable regional framework and fostering a new national conversation about asylum seekers.

The AHRC Pathways to Protection report (2016) explores rights based alternatives to offshore processing. It identifies barriers to taking such an approach, namely that there are few effective mechanisms for cooperation on refugee issues in the region and that there are limited opportunities for safe entry. To overcome these barriers the report outlines a number of policy options that would expand opportunities for safe entry and enhance foreign policy strategies in the Asia-pacific region. These options include a range of legislative reform related to visa categories, the expansion of private and community sponsorship, increased funding for humanitarian agencies, bilateral regional dialogues and enhancing regional preparedness for flight by sea.
Together these reports call for the resumption of regional dialogue and diplomacy. They also provide a working model for such dialogue. These reports move beyond the lie promoted by the government that deterrence is the only means of saving lives at sea and instead call for fair and transparent processing, regional cooperation and the need to make journeys safer. The similar issues experienced with irregular migration by sea in the Mediterranean have led to calls for not just safety on arrival, but safe and legal routes (Medecins Sans Frontieres, 2015).

Beyond simply calling for policy change in this area, regional reform should be a central demand in any future action. This leads to a caution on action in this area. While the above two reports call for regional solutions that are relatively comprehensive, protest has often focused on one aspect of this policy. This was discussed in Chapter 6 in relation to the #LetThemStay campaign (Hall et al., 2018). While such an approach is understandable and often targeting the harshest elements of these policies, protest should not lose sight of longer term sustainable regional solutions.

7.5.6 International Pressure and Global Justice

A final area that has often been overlooked relates to facilitating and promoting international pressure. In other words, creating and placing pressure on the Australian government externally, rather than from within Australia. While the government has responded with hostility to a number of international human rights organisations, there are a number of other potential courses of action that deserve consideration. Furthermore, there is a growing literature, closely related to social movement theory on what could best be called transnational contention, which has increasing potential to guide action in Australia (Bell, Clay, & Murdie, 2017; Pianta & Marchetti, 2012; Tarrow, 2012).

One avenue for action would involve bringing to light Australia’s approach through international media (Laney et al., 2016). More modestly anyone who travels internationally could expose Australia’s policies, whether on business or as a tourist. To maximise the impact of such action, opportunities that put Australia in the spotlight could be seized, international business, political or sporting events, capitalising on existing publicity and world attention. Australian clinicians and professional bodies should also call on their international peers to condemn Australia’s policies.
There is of course international law. While little action has been taken to this point, petitions should continue. The consequences of Australia’s policies should continue to be highlighted; including its parallels to torture (Doherty & Hurst, 2015; Essex, 2016d) or as possible crimes against humanity (Doherty, 2017b). This remains important in continuing to place pressure on the Australian government and companies who enforce these policies. It could also be important in any future prosecutions. If such action were to occur, clinicians who have worked within immigration detention centres should have a central role in any future prosecution (Barnes, 2018), particularly in highlighting the harms of this system.

Finally the possibility of a boycott, divestment and sanctions campaign aimed at Australia more generally should be debated (Loewenstein, 2017). This of course could involve any of Australia’s exports or even those thinking of travelling to Australia. While a total boycott of Australia is unlikely, such calls would be a provocative way of gaining further support and highlighting the harm Australia is doing globally, serving to place further pressure on the Australian government.
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Portfolio of Published Work

Statement on Portfolio

Below, eleven articles that were published during my candidature are included as part of a portfolio of published work. They all share some common features. They are all focused on health and healthcare in Australian immigration detention. All are critical of the Australian government's approach to health and healthcare and all highlight the harms of this system. They are presented in order of publication, from earliest to most recent. This provides some insight into how my thinking on Australian immigration detention evolved during my candidature, with one exception. “Mental health of children and families in Australian alternate places of immigration detention” was written with Poonka Govintharajah, Psychologist, former colleague and friend, in late 2014 before the AHRC Forgotten Children report (2014) was released and the Border Force Act (2015) was passed. It was ready for publication in mid-2015, however with the Border Force Act (2015) coming into effect, we did not attempt to publish it until late 2016 after it was amended. Similarly other articles cannot be completely understood without considering the impact of the Border Force Act (2015). “Healthcare and clinical ethics in Australian offshore processing centres” was written before the introduction of this legislation, with the intention of including it as a literature review in my originally proposed research.

Despite many of the difficulties I had, I was also fortunate to be writing a thesis in an area which was accessible and where many clinicians, academics and journals took an interest. Among their other contributions to the literature, many of the articles here serve to highlight the ongoing abuse by the Australian government. For example, “Australia's immigration centres are no place for children” was written in response to an editorial in the Lancet, a journal which has long been critical of Australia’s approach to refugees and asylum seekers.

Other articles were focused on particular incidents in detention. “Ethics, foreseeability, and tragedy in Australian immigration detention” was written after the death of Hamid Kehazaei an Iranian asylum seeker detained on Manus Island. I concluded by saying that “the next
tragedy is not only foreseeable but inevitable” (p. 539). Since this time many others have died in circumstances that were both completely foreseeable and avoidable. The most important point in this article, at least as it pertains to this thesis, is that the harm created and perpetuated by Australia’s policies is not accidental or due to negligence, it is deliberate. While these insights were perhaps lost on me at the time, this meant that any response did not just need to act to change systemic shortcomings or negligence, but planned, deliberate harm. “A community standard: Equivalency of healthcare in Australian immigration detention” builds on this thinking, in particular arguing that not only is providing healthcare to a standard found in the broader Australian community impossible under the circumstances, but that it makes little sense to do so given the ongoing and deliberate harm promoted by these polices.

The article “The ethics of discharging asylum seekers to harm: An example from Australia” written with Professor David Isaacs, explores the case of Baby Asha, a case which was discussed throughout this thesis. This article was particularly important in shaping my thinking on a range of issues, the power of collective action, utilising the media and the relative power that clinicians hold. It was written at a time when I was becoming increasingly interested in social movement theory, how this could help explain action and more importantly, utilised as a foundation for future action.

“Torture, healthcare and Australian immigration detention” was written after an invitation from the Journal of Medical Ethics that sought to publish a series of articles exploring the parallels between Australian immigration detention and torture, and what this meant in relation to a boycott. “Healthcare and complicity in Australian immigration detention” was written at about the same time. I briefly discussed this article in Chapter 4 in relation to a boycott as it explicitly conflicts with my position in this thesis. An explanation is warranted. In this article I outline and apply Lepora and Goodin’s (2013) framework of moral complicity to healthcare in Australian immigration detention and particularly whether clinicians should boycott. In this article I stated that “current engagement with Australian immigration detention cannot be justified on balance” (p. 145) and that a “boycott may therefore be justified if it does not disproportionately impact those detained” (p.145). Context is needed as to how I came to this conclusion. First, this article was written after the introduction of the Border Force Act (2015), as I have also discussed throughout this thesis if clinicians can do nothing more, they should speak of their experiences. Such action has proven powerful. With the introduction of the Border Force Act (2015) this was no longer possible, restricting what I saw to be the most
powerful action clinicians could take. Second, I overlooked all possible scenarios that could eventuate from a boycott. As was discussed in my thesis above, while we can begin to quantify the pros and cons of ongoing engagement within detention, we cannot say with any certainty what might happen after a boycott occurs. Furthermore, I failed to deal with many of the practical issues raised in this thesis. A boycott would only be successful with near universal support from clinicians and professional healthcare bodies, this is unlikely to happen. My wider reading on social movements and social movement theory informed this position, but it also led me to believe that a boycott shouldn’t be dismissed completely, but instead seen amongst a broader repertoire of action.

Written most recently, “Health, social movements, and Australian immigration detention” and “Psychology and its response to major human rights abuses: The case of Australian immigration detention” overlap most closely with the arguments made throughout this thesis. In each of these articles I argue that clinicians should embrace a movement based approach, when faced with major human rights abuses and a recalcitrant government. “Psychology and its response to major human rights abuses” in particular makes a number of similar arguments to what I have put forth here and discusses the case studies I introduced in Chapter 6.

The final section also includes an “Open letter on the Border Force Act” published by The Guardian Australia (2015). While I was only signatory to this letter, it is included here because of its personal relevance and relevance to this thesis. I signed this letter about a week before it was published by The Guardian Australia, the day the Border Force Act came into effect on 1 July 2015. The letter was released with an article I wrote for The Guardian (Essex, 2015b) and more importantly in conjunction with a coordinated plan to promote it in the Australian media. I signed this letter knowing the government could prosecute. It’s included here because I think it’s important for me to practice what I preach. While many people won’t be in a position to take such action and while others (understandably) may not want to take such risks, I hope this thesis and actions such as this lead more clinicians down this path, when presented with an opportunity to resist or disrupt, they take it and make no apologies.
The death of Hamid Kehazaei, an asylum seeker detained on Manus Island, has raised a number of questions surrounding the medical treatment he received and whether a move to mainland Australia, if expedited, could have saved him. He died of severe septicaemia from an infected cut, and the circumstances surrounding his death were largely unknown until medical documents were recently obtained by the Australian Broadcasting Corporation (ABC) (Willacy, Solomons, and McDonald 2014). In these documents it was revealed that all treatment options on Manus Island had been exhausted, with recommendations for a transfer for further treatment made by International Health and Medical Services (IHMS), the medical provider on Manus. The initial request for a transfer to Port Moresby was made on August 25, 2014, which was subsequently delayed for more than twenty-four hours. He was then transferred to Brisbane on the afternoon of August 27 and pronounced dead on September 5. The ethical issues raised by this case are not isolated and are only part of long-term systemic failings that have compromised the health and well-being of those in immigration detention.

According to the The Border Crossing Observatory (2015), there have been at least thirty-four deaths in immigration detention or community detention since 2000. At least eleven of these were suicides or suspected suicides. Hamid Kehazaei is one of three individuals who have died in offshore detention. These deaths have been set to a backdrop of epidemic levels of self-harm and poor physical and mental health. The immigration department itself acknowledged the link between prolonged immigration detention and deteriorating mental health at the Australian Human Rights Commission (AHRC) hearings into children in detention (Marr and Laughland 2014).

The devastating impact immigration detention has upon health and multiple deaths in custody have prompted numerous investigations. The Commonwealth Ombudsman’s (2013) report into suicide and self-harm in immigration detention was critical of how policies and practices were implemented. Specifically, and with particular resonance for the above case, the Ombudsman commented on the placement of asylum seekers within the detention network in relation to their health and well-being. At the time, these decisions were guided by the Detention Facility Client Placement Model. This model guided placement decisions for onshore detention; it is not clear how placement is determined in offshore locations.

The department’s duty of care to detainees extends to the decisions it makes about where a detainee is placed in the detention network. For example, if a person detained in a detention facility in a remote location requires medical services that are not practically available to them in that facility, then the department’s duty of care may require it to relocate the detainee to another facility where those services are available (Commonwealth Ombudsman 2013, 87).
During the AHRC hearings into children in detention, Dr. Peter Young, the former medical director of IHMS, gave a first-hand account of the harms of immigration detention, along with the immigration department’s disregard for medical advice, warning about delays in transferring asylum seekers to the mainland for treatment.

It is seen as undesirable because it undermines the idea that people are never going to Australia and also because of the concern that if people arrive onshore then they may have access to legal counsel and other assistance (Marr and Laughland 2014, ¶7).

These concerns were further supported when the ABC revealed documents that provided a confidential assessment of IHMS’ performance by the department of immigration in providing medical care and meeting contractual arrangements (Om 2014). The findings were based on a meeting of eight senior bureaucrats and accused clinicians of advocating for asylum seekers, including recommending excessive medical procedures. Frustrations were also noted about clinicians recommending asylum seekers be transferred to the mainland for treatment. To address these concerns, the report suggested that IHMS hire clinicians who were able to better follow the contractual requirements and who were not against offshore processing. According to this report, IHMS would be risking its contract with the department if the concerns were not addressed.

The long-standing reluctance of the immigration department to follow medical advice (e.g., Australian Heads of Schools of Social Work [ACHSSW] 2006) reflects the level of control it maintains over detention centres and how drastically the department’s interests diverge from clinicians working within the system. For those who work in immigration detention, the lack of clinical independence is an overarching ethical issue, with clinicians compromised by the additional obligations placed on them by the department and IHMS (e.g., Coffey 2006; Essex 2014). These systemic failures and the pressure placed on clinicians to conform to a damaging system often go unreported; however, there are a number clinicians beginning to speak about their experiences in detention, showing the extent to which medical recommendations are subordinated by other policies.

A number of such ethical issues were highlighted by a letter written by fifteen doctors to IHMS and subsequently provided to The Guardian in late 2013. The letter revealed the inadequate conditions under which IHMS provided medical treatment on Christmas Island and that underpinning almost all of these complaints was the fact that patient care was compromised by IHMS’ relationship with the department of immigration (Laughland and Marr 2013). The letter states:

A conflict of interest exists, as a result of IHMS’ relationship with the Department of Immigration and Border Protection that can influence decisions regarding patient care. Decisions made by IHMS do not appear to have always been made in the best interest of patients. The shifting of responsibility between the DIBP and IHMS is likely to result in neither party acting appropriately in regards to patients (Names redacted in The Guardian 2014, 5).

Furthermore these decisions place medical and nurse practitioners at great medico-legal risk, a fact that goes uncontested by management at staff meetings and yet has not been addressed. Management states that the Department of Immigration are accepting all responsibility. However, no third party has the power to absolve health practitioners of their duty of care to patients and we must all adhere to AHPRAs code of conduct (Names redacted in The Guardian 2014, 29).

The doctors specifically raised concerns about the placement of patients, providing a number of salient examples.

During these delays, medical staff attempt to manage these often complex and painful conditions with ad hoc and temporising measures. The waiting time is indeterminate and no advice can be given as to when a person is to leave for definitive care. … The conditions can be so severe that they risk life-threatening deterioration. Cases include an individual with an imminent risk of sepsis from surgical pathology, complications of a pacemaker insertion in a child and fevers in a patient with undifferentiated immune-compromise (Names redacted in The Guardian 2014, 32).

Despite multiple warnings, numerous investigations, and the dire health of those detained, little has been done to address the numerous systemic failures and barriers to providing ethical healthcare in immigration detention.
One of the greatest tragedies of the Hamid Kehazaei case is the fact that the issues surrounding it were long known, as was the fact that treatment recommendations were regularly subordinated to the department’s interests. Such issues were raised by multiple individuals and enquiries in the months and years leading up to Hamid Kehazaei’s death. The idea of a coordinated response, including discussing the implications of a boycott by healthcare professionals, was raised by a number of doctors who were involved in writing the above Christmas Island letter (Sanggaran, Ferguson, and Haire 2014). What is certain is that change is now long overdue and that bold action is needed, because as long as healthcare in immigration detention remains compromised and undermined, the next tragedy is not only foreseeable but inevitable.

**Update**

Since this editorial was written in mid-2014, there have been four further deaths related to Australia’s asylum seeker policies, two in onshore immigration detention centres (The Border Crossing Observatory 2015). There also have been a number of investigations that have detailed widespread sexual and physical abuse, self-harm, suicide, and mental health issues in offshore immigration detention centres (Australian Human Rights Commission 2014; Moss 2015; Select Committee on the Recent Allegations Relating to Conditions and Circumstances at the Regional Processing Centre in Nauru 2015). This has all occurred while the government has passed legislation that could send clinicians to gaol for up to two years for raising concerns about abuse and neglect (Hoang 2015).

A Coronial Inquest in Queensland into the death of Hamid Kehazaei also has recently begun. It is hoped that this sheds further light on the above events and is a step toward change and justice.

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Torture, healthcare and Australian immigration detention

Ryan Essex

Australia has arguably led the developed world in implementing the most damaging and regressive measures aimed at deterring asylum seekers and refugees. The harms of this system have long been documented and only re-enforced more recently in a number of investigations that have detailed riots, violence and widespread physical and sexual abuse in offshore detention, with adults and children reported as victims.1 2

After time spent in an offshore processing centre on Nauru, Isaacs has emerged as a vocal critic of Australia’s immigration detention policies. In his article,3 he argues that the mandatory and prolonged detention of asylum seekers and refugees is analogous to torture, drawing comparisons between Australian immigration detention and other notorious sites where torture has taken place. This provocative argument gives a new urgency for long overdue action. Similar concerns have also been raised by other former clinicians and academics (J-P Sanggaran and D Zion. Is Australia engaged in torturing asylum seekers? What this means for medical practise and legislation. Manuscript in preparation.) and follow from comments from the United Nations accusing Australia of systematically violating the preparation.) and follow from comments from the United Nations accusing Australia of systematically violating the

The compromised nature of healthcare has now been well documented6 9 along with the pervasive nature of dual agency (or dual loyalty) obligations, between that of patients, the immigration department and other contractors.10 This has only served to restrict and distort the nature of healthcare and limit clinicians in their roles with healthcare frequently subverted to other policy goals. Accountability is obscured and oversight is limited with arrangements that attempt to divest responsibility from the immigration department. At best clinicians are required to navigate ethically fraught terrain where they frequently have to compromise what may be ideal or even generally accepted treatment, at worst this promotes conduct that is clearly unethical. Along with the detention environment this all serves to curtail what benefits may usually be gained from treatment. These issues have played out in a more acute form in offshore detention where there has been a number of examples of the immigration department intervening in medical transfers and treatment recommendations.2 11

A leaked report that shed light on the extent of these tensions was obtained by the Australian Broadcasting Corporation.12 Centred around the performance of the detention healthcare provider (International Health and Medical Services; IHMS), this report revealed that IHMS risked losing its contract if a number of the immigration department’s concerns were not addressed including clinicians ‘advocating for transferees beyond the services IHMS is contracted to deliver’ and that ‘IHMS need to ensure medical staff who do reviews are not against Offshore Processing Centres (OPCs)’.

Isaacs rightly identifies the important role former clinicians have played in bringing to light these issues and how they are now limited in speaking about their experiences, faced with the prospect of 2 years’ gaol. It is noteworthy that many of the sources cited by Isaacs and this article would now be illegal under recently introduced legislation. This has come at a time when the government has attacked and attempted to silence critics13 while also covering up allegations of abuse1 2 14 and has been one of many recent regressive steps that has only served to diminish clinicians’ capacity to act in their patients best interests and advocate for change. What good can be done in such environments? Recent events suggest less and less.

So on balance can clinicians continue to justify their involvement in Australian immigration detention? Isaacs argument, along with the recent steps that have been taken to limit and increasingly compromise the role of clinicians are compelling arguments among others for a boycott, however this article stops short of calling for this as has been done previously.15 16 Isaacs instead calls for clinicians to carefully weigh their options in regards to engaging with this system, giving yet another reason for clinicians to rethink their involvement and for significant reform.

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Children in Australia’s immigration centres

A Lancet Editorial (Feb 13, p 620) highlights the ongoing and widespread abuse in Australia’s offshore immigration detention centres, in light of the recent High Court decision that ruled offshore detention of asylum seekers to be legal. While these issues are alarming on their own, they have come at a time when the government has taken steps to silence dissent and promote secrecy in Australia’s detention process. One of the more publicised aspects of this government intervention was the introduction of the Border Force Act. This law makes it a criminal offence for any current or former employees to discuss or record any aspect of their time in immigration detention, and included clinicians, teachers, and other support staff.

These unprecedented and regressive measures are increasingly being met with resistance, with clinicians often leading this action. After the introduction of the Border Force Act, over 40 former detention centre employees, including doctors, nurses, and social workers, signed an open letter challenging the government to prosecute, protests were staged across the country, and many former staff continue to speak defiantly despite risk of prosecution. More recently, a number of hospitals have refused to discharge children if they are to be returned to detention. There is little doubt that the present situation in Australia is exceptional, with clinicians continuing to put themselves at risk as a means to highlight these issues and lead the way to change.

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Healthcare and complicity in Australian immigration detention

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Abstract Australian immigration detention has received persistent criticism since its introduction almost 25 years ago. With the recent introduction of offshore processing, these criticisms have intensified. Riots, violence, self-harm, abuse and devastating mental health outcomes are all now well documented, along with a number of deaths. Clinicians have played a central role working in these environments, faced with the overarching issue of delivering healthcare while facilitating an abusive and harmful system. Since the re-introduction of offshore processing a number of authors have begun to discuss the possibility of a boycott. While taking such action may lead to change, further discussion is needed, not only in relation to the impact of a boycott, but whether it is possible for clinicians to engage with this system in more productive, ethical ways. This article utilises a framework proposed by Lepora and Goodin (On complicity and compromise, Oxford University Press, Oxford, 2013) that provides a structured approach to examine complicity and seeks to explore how clinicians have engaged with Australian immigration detention and ultimately whether they should continue to do so.

1 Australian immigration detention

Australia maintains immigration detention centres on the mainland (and Christmas Island, a remote Australian territory) and offshore locations, Manus Island (Papua New Guinea) and Nauru. These centres house refugees and asylum seekers, often for protracted (and in some cases, indefinite) periods of time. This policy has been
maintained by both major political parties with the primary aim of deterring further asylum seeker arrivals (Phillips and Spinks 2013).

Australia’s policy of mandatory immigration detention has long been controversial and has been extensively criticised. These criticisms have included claims that this policy violates and undermines international law and human rights (Australian Human Rights Commission; AHRC, 2012, 2013, 2014). Extreme violence, riots, self-harm and suicidal behaviour are common (Australian Parliamentary Select Committee 2015; Moss 2015) and the devastating impact this system has on health has been well established (Bull et al. 2013; Green and Eagar 2010; Sultan and O’Sullivan 2001; Young and Gordon 2016), including epidemic rates of self-harm and suicidal behaviour (Dudley 2003). There have also been multiple deaths, many due to violence and suicide (The Border Crossing Observatory 2016). Immigration detention and particularly offshore detention operates with limited accountability, with the government attacking or silencing critics (Australian Parliamentary Select Committee 2015; Om 2014, 2015; Borrello and Glenday 2015). Arguably the most alarming attempt to increase secrecy in relation to immigration detention centres was the introduction of the Border Force Act. This legislation came into force on July 1st 2015 and made it a criminal offence for former and current staff to disclose or make a record of any information obtained in their capacity as an employee, punishable by two years imprisonment (Newhouse 2015). As a whole these policies have been called state sponsored abuse:

Over the past twenty years, such policies have inflicted a scale of systemic abuse on unauthorised refugees that can justifiably be described as state crime. While this can be illustrated by the extensively documented and entirely foreseeable cases of physical injury, trauma, self-harm and suicide within Australia’s immigration detention centres, the state crime associated with border policing fundamentally rests on the alienation, criminalisation and abuse of those with a legitimate reason to seek entry into Australia and a legitimate expectation that they should be allowed to do so (Grewcock 2013, p. 11).

Others have drawn parallels between torture and Australia’s policies. Peter Young, Psychiatrist and former Medical Director of International Health and Mental Services (IHMS) suggested that this system was purposefully harsh and designed to create suffering as a means of deterrence (Marr and Laughland 2014). Similar sentiments were echoed by Isaacs (2015a). Criticisms have also come from the United Nations, accusing Australia of systematically violating the international Convention Against Torture by detaining children and holding asylum seekers in dangerous and violent conditions on Manus Island (Doherty and Hurst 2015).

2 Clinicians, healthcare and Australian immigration detention

The immigration department in Australia provides health services in immigration detention centres through its contracted provider International Health and Medical Services (IHMS), local hospitals and other contracted allied health professionals.
IHMS has held the contract to deliver health services in immigration detention since 2007. The value to detention health contracts since 2009 was estimated to be approximately $1.6 billion dollars (Farrell 2015a, b).

There is a growing body of evidence that has documented the challenges faced within detention centres (Briskman and Zion 2014; Coffey 2006; Essex 2014, 2016a; Isaacs 2015b; Sanggaran et al. 2014). Those working within the system are compromised from the outset, with government policies not only negating any clinical gains but actively working against any reasonable standard of health and healthcare. Former clinicians have spoken extensively about this disempowerment along with an inability to address what are essentially systemic issues. Even at the highest managerial and administrative levels healthcare appears to be subverted to government policy and security objectives (Australian National Audit Office 2016; “Christmas Island Medical Officer’s Letter of Concern” 2013; Farrell 2015a, b), with arrangements set up to blur responsibilities and largely divest government of accountability in relation to the health and wellbeing of asylum seekers (Australian Senate Legal and Constitutional Affairs References Committee, 2014; “Christmas Island Medical Officer’s Letter of Concern” 2013; Mares and Jureidini 2004).

While the literature discusses a spectrum of responses from clinicians working in immigration detention centres, from those acting recklessly and engaging in abuse, to those who have carefully considered their roles, the issue of complicity remains. That is by virtue of being involved clinicians facilitate the harm caused by the Australian government. Using complicity as a starting point the remainder of this article will examine the harm to which clinicians have contributed, whether this may be justified on balance and ultimately whether they should continue to engage with Australian immigration detention.

3 Complicity in Lepora and Goodin’s model

Healthcare’s engagement with the wrongdoing of others is not uncommon and may occur in a range of circumstances. Although many organisations and individuals attempt to make a positive contribution, even with the best intentions, many have to engage with the wrongdoing of third parties to do this work. Lepora and Goodin (2013) propose a framework that uses complicity to begin to discuss such problems, providing a structured approach to examining the degrees to which agents may engage with wrongdoing. This framework provides a starting point to begin to discuss the issues that arise in Australian immigration detention and move toward answering how and whether clinicians should continue to engage in these environments. Lepora and Goodin suggest this model is used as a pragmatic tool to guide thinking, at the very least serving, “as a useful heuristic in reminding us what questions we need to ask in assessing acts of complicity morally and comparing them with alternative courses of action” (p. 103).

Firstly, in defining complicity, Lepora and Goodin suggest a minimum threshold. In short the threshold proposed is one where agent’s may contribute knowingly in
some way to wrongdoing, but not necessarily share the same intentions as the principal wrongdoer. In their words:

Thus, in our view, voluntarily performing an action that contributes to the wrongdoing of another and knowing that it does so (but without necessarily sharing the other’s wrongful purpose), represent the necessary actus and mens conditions, respectively, that are minimally required for one to be complicit with the wrongdoing of another (p. 83–84).

This minimum threshold for complicity, therefore requires (a) a voluntary contribution (b) knowledge (or culpable ignorance) of the contributory role their actions, and (c) knowledge (or culpable ignorance) of the primary wrongdoing to which they are contributing (p. 83). This is notably less stringent than what may be generally found in legal doctrine, that “not only awareness but also fully joint action and a meshing of purposes are necessary conditions to be morally to blame for complicity” (p. 83). The proposed definition gives greater scope to examine circumstances found in particularly problematic healthcare environments, such as Australian immigration detention.

The degree to which an agent may be complicit is influenced by a number of factors, requiring a number of questions to be asked, most importantly, how bad the principal wrongdoing was, whether the agent voluntarily and knowingly contributed to it, how much of a contribution was made and to what degree the agent shared in the principal wrongdoer’s purposes. Note that it is not necessary to have shared purpose in the wrongdoing as per the minimum threshold proposed above, however agents who share wrongful purposes may engage in two wrongs, the first being the contribution to the wrongdoing, the second in sharing wrongful purposes with the principal wrongdoer. In short:

\[ \text{pro tanto blameworthiness for an act of complicity} = \text{function of (badness of principal wrongdoing, responsibility for contributory act, extent of contribution, extent of shared purpose with principal wrongdoer)} \] (p. 98).

Breaking this down further, there are a number of factors that make up what Lepora and Goodin call the responsibility factor, contribution factor and shared purpose, these are outlined in Table 1. In assessing responsibility for the contribution it is necessary to consider the voluntariness of the contribution, knowledge of the contribution (Does the secondary agent know that what she was doing could contribute to something the principal agent was doing?) and knowledge of the principal wrongdoing. In assessing what Lepora and Goodin call the ‘contribution factor’ it is necessary to consider how causally central the agents actions were to the principal wrongdoing, how proximate the secondary act is to the occurrence of the principal wrongdoing, whether the secondary contribution is reversible, whether the wrongdoing is part of an ongoing pattern of similar wrongdoing, whether the secondary agent has a role in the planning of the principal wrongdoing and how responsive the secondary agent is to the plan of principal wrongdoing and to others’ actions in implementing it. In assessing the extent to which a secondary actor shares purpose with the wrongdoing it is necessary to consider the extent to which the purposes of the secondary agent overlap with the principal wrongdoer, the strength
of this purpose, and the extent to which these shared purposes guide the contributory action.

A final question remains, namely that despite the wrongdoing, whether or not becoming complicit was still the right thing to do on balance. To answer this the following question needs to be asked, “how much bad was done by the act of complicity, compared to how bad would have been the alternative courses of action available to the agent” (p. 7). Lepora and Goodin suggest that for an overall assessment, moral credit and blame should be weighed under each of the above headings.

4 Evaluating complicity in Australian immigration detention

The model presented above provides a starting point to consider the issues in Australian immigration detention. The most morally relevant aspects of this model and how it may apply to Australian immigration detention will be discussed below.

In first assessing what Lepora and Goodin refer to as the ‘responsibility factor’ there is little doubt that all clinicians in Australia would engage voluntarily and that they would be aware of the general controversies that surround immigration detention. There have been a number of high profile cases where clinicians have testified and reflected upon their experiences, with extensive information available that details the difficulties in delivering healthcare in these environments (e.g., Laughland 2014a; Marr and Laughland 2014). Beyond the general controversies however, would clinicians have been aware of the extent of wrongdoing in all circumstances? One example relates to confidentiality and the use of medical information. There have been numerous instances where medical information has been disclosed to non-medical staff, including the immigration department, with this information interfered with or used for political purposes (Australian Parliamentary Select Committee 2015; Marr and Laughland 2014). Were clinicians complicit in this instance? Assuming that majority of clinicians maintained confidentiality, a key consideration would be whether clinicians could reasonably foresee this information being misused. In this case it would be safe to assume that many didn’t.

Table 1 Pro tanto blameworthiness for an act of complicity = function of the badness of principal wrongdoing (BF), responsibility for contributory act (RF), extent of contribution (CF), extent of shared purpose with principal wrongdoer (SP)

<table>
<thead>
<tr>
<th>Responsibility factor (RF)</th>
<th>Contribution factor (CF)</th>
<th>Shared purpose (SP)</th>
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<tbody>
<tr>
<td>Voluntariness</td>
<td>Centrality of contribution</td>
<td>Shared Purpose (Extent of overlap)</td>
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<tr>
<td>Knowledge of contribution</td>
<td>Proximity of contribution</td>
<td>Strength of shared purpose</td>
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<td>Knowledge of wrongness of principal wrongdoing</td>
<td>Reversibility of contribution</td>
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<td>Responsiveness of contributors to principals</td>
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While it is conceivable that the Australian government may be able to carry out aspects of its policies without the involvement of clinicians, it is difficult to see how immigration detention could function without their involvement. In making this point and beginning to assess what Lepora and Goodin would call the ‘contribution factor’, it is worthwhile considering what immigration detention may look like without healthcare. Health assessments, emergency care and treatment could no longer be provided on site. Given the need for medical assistance, including a frequent need for emergency intervention it is difficult to imagine how this may be managed externally. Remote centres including Manus Island and Nauru would likely have to shut down or be relocated due to the overwhelming stress placed on external healthcare services with the majority of urban detention centres forced to do the same or make significant changes to their day to day operation.

Beyond this overall contribution, clinicians also provide a range of services that serve the interests of maintaining security and order within centres. They conduct assessment and intervene to manage difficult behaviours, they are used to defuse potentially dangerous situations, dealing with those who may be distressed or violent. While in many circumstances these are legitimate clinical activities, they are also central to maintaining order within detention centres and unavoidably facilitate the day to day running of centres. This is also unavoidable in relation to more orthodox treatment (particularly in relation to mental health), unable to address the underlying systemic issues, and clinicians at best maintain detainees to face further detention.

The involvement of clinicians also lends a veil of restraint and legitimacy to these environments. While this is subtle and may manifest in a number of ways the government has long used healthcare as a buffer to the brutality and abuse faced in these environments. One example of this relates to the government’s longstanding claim that healthcare within Australian immigration detention is provided to a standard found within the broader Australian community. This claim is unfounded and even deceptive (Essex 2016b) but has generally gone unchallenged. The government has continued to re-enforce this message despite devastatingly poor health outcomes and even in the face of tragedy (Laughland 2014b).

Another consideration in relation to Lepora and Goodin’s ‘contribution factor’ is how responsive clinicians have been in contributing to wrongdoing. In other words, clinicians may choose to adopt the immigration departments’ objectives and fulfil these roles without question and be completely responsive, others may advocate for those detained and even actively engage in subversion (Briskman and Zion 2014). In the literature, responses from clinicians have been varied, some have carefully considered their roles, while others have highlighted a “culture of acceptance” that exists in relation to health services (“Christmas Island Medical Officer’s Letter of Concern” 2013) or discussed the more subtle ways clinicians may re-enforce the dehumanising nature of detention (Koutroulis 2003). A particularly problematic example of this relates to clinician involvement in deportations, with a number of stark examples documented. This may be approached in a number of ways with some framing their assessments broadly, warning of the consequences of such action and advocating for the individual in question. Others have played an active
and possible planning role in deportations. The People’s Inquiry into Detention received an account of an attempted deportation (ACHSSW 2006):

The doctor entered the cell carrying an injection with four tablets, asking me to choose either the injection or the tablets. I refused both. The doctor offered the security officers to do their job and he and the officers laid me down on the floor and sit on my back, took my pants down. Then I accepted to receive the tablets. They didn’t work, so they force me to take a fifth tablet at the airport. They got me on the airplane with a wheelchair accompanied by a nurse, two companions and three other ACM officers, with three types of handcuffs and ties of leather, plastic and steel around my hand and belly that gathered my arms to my trunk.

Clearly, one approach is more problematic than the other, with the clinicians in the case above being significantly more responsive to the principal wrongdoing of the immigration department. In this case, the clinician in question also likely share purpose with the government, which is also the final factor contributing to moral blameworthiness in Lepora and Goodin’s model. Despite the above example, such unethical behaviour remains rare and it would still be reasonable to suggest that the majority of clinicians who engage with this system do so with good intent with largely divergent purposes to that of the Australian government.

5 Minimising complicity with wrongdoing

There are a number of ways to minimise complicity with wrongdoing. Lepora and Goodin note clinicians can reduce their complicity by engaging in acts that prevent or help redress wrongdoing. In doing so, they suggest that clinicians first assess the potential consequences of different courses of action (including its impact on themselves, the patient and society), discern and follow requests from the patient about his or her care and weigh the degree to which the act would be complicit in wrongdoing.

There is a modest literature that has attempted to address how clinicians may better navigate Australian immigration detention. Working within immigration detention there appears to be some scope for clinicians to reduce their responsiveness to the objectives of the immigration department. This may be achieved by subversion and advocacy, what some have called, “dispensing acts of kindness that may not be valued or even prohibited by the employing or subcontracting authority” (Briskman and Zion 2014, p. 279). There are a number of other measures clinicians may take including conveying and acting upon their patients’ wishes, framing assessments and recommendations broadly and conveying the risks of not acting upon these. There may also be some scope to avoid particularly problematic aspects of their role such as involvement in deportations. Unfortunately all evidence suggests this may be significantly more difficult in practice and it may in fact be more productive for clinicians to walk a moderate line, engaging in negotiations with the immigration department and centre management to achieve the best outcomes:
The tensions though, in how far one takes recommending alternative arrangements, are obvious. Not to do so is to remain silent about a significant and perhaps determinative effect on the detainee’s prognosis. Some might argue that it is to collude with the convenient lie that extended detention can be psychologically benign. Conversely, making recommendations about services that are not available, or regularly insisting on the need for the detainee to be released, risks detracting from the measures that can be taken immediately. It is an approach that runs the risk of having recommendations dismissed as advocacy, of alienating the IDC [immigration detention centre] management and the Department and therefore jeopardising the relationship between the IDC and the mental health service, and of leaving the IDC health staff feeling helpless (Coffey 2006, p. 76)

Despite being able to minimise complicity in a number of ways, through careful negotiation and small acts of resistance, there is limited scope to address what are essentially systemic issues working within immigration detention. Clinicians working in these environments still face a number of irreconcilable conflicts, even the most careful clinicians can do little to redress the harm done by these environments’ and continue to contribute to its function in both material and non-material ways. Furthermore, in the case of Australian immigration detention, minimising clinician complicity with wrongdoing is unlikely to lead to significant improvements in the health and wellbeing of those detained.

6 Should clinicians continue to work in Australian immigration detention?

Discussions related to boycotting Australian immigration detention were in large part motivated by the increasingly regressive policies introduced by the government and the fact that all other means of action have failed to bring about change (Berger and Miles 2016; Isaacs 2015c; Sanggaran et al. 2014). Lepora and Goodin’s model provides some assistance in answering whether clinicians should continue to engage in such circumstances. As discussed above, according to this model clinicians may justify becoming complicit with wrongdoing if it was still the right thing to do on balance, or asking “how much bad was done by the act of complicity, compared to how bad would have been the alternative courses of action available to the agent” (p. 7).

Arguably one of the most important roles clinicians have played is witnessing and speaking out in the face of abuse (Essex 2016a, b; Isaacs 2015a, b, c; Sanggaran and Zion 2016; Zion et al. 2009). Giving insight into abuse, violence and the damage that immigration detention has done may arguably be the most good that clinicians have achieved in relation to Australian immigration detention. Unfortunately with the introduction of the Border Force Act the ability to speak about immigration detention is now severely restricted placing clinicians at significant personal risk.
What alternate courses of action are available to clinicians? Despite long term opposition from clinicians and professional bodies, including advocacy, protest and even civil disobedience, Australia’s detention policies are arguably more harmful than ever (Doherty, 2016; Safi and Farrell 2015). While clinicians may reduce their complicity by engaging in subversion and advocacy within immigration detention, they are likely to achieve little in relation to improving the health and wellbeing of those detained. This was summed up by a mental health professional during the People’s Inquiry into Detention:

You could have the Rolls Royce of mental health services in Baxter and I don’t think it would make a scrap of difference, because the environment is so toxic that you can’t treat anything meaningfully. I think that half a dozen of the most damaged people that I’ve ever seen are the adults that I’ve seen in Baxter and Woomera, both parents and single men. The thing is that it is all caused by being in detention. Provided you get them in time, you take these people out of detention and they’re not depressed any more. Of course the interpretation of that from DIMA is to say they’re putting it on, “Isn’t it convenient for them, the thing that was going to cure them from their depression is taking them out of detention.” The reason it’s going to cure them is because detention is a place that drives people mad and yeah, they want to get out of the place that is driving them mad (ACHSSW 2006, p. 44).

The good that clinicians can achieve working within Australian immigration detention is negligible, while the harm they have facilitated has been called state sponsored abuse and akin to torture. There is little way to justify engagement with this system on balance. Taken into account with the fact that all other forms of action have failed to achieve change, there is a strong argument to boycott Australian immigration detention.

However, there remains a number of other considerations. Lepora and Goodin’s model remains open to interpretation. Weighing the principal wrongdoing to which clinicians are complicit, against the good that can be achieved in these environments’ is a difficult and complex task, as they note, “exactly how and how much consequences matter in moral decision-making is controversial. It is notoriously hard to weigh the importance of different states of affairs against each other, let alone against very different values, such as avoiding complicity” (Lepora and Goodin 2013, p. 159). This model also provides very little guidance on how to weigh the “good” that clinicians may achieve. In a more practical sense, the aims of any further action (including a boycott) need to be better articulated. The exact nature of a boycott needs to be discussed. Should we leave emergency staff in centres? Should conditions be placed on any further engagement? Furthermore, should other action also be taken to complement a boycott? For example a boycott may fail to address the larger social and political issues that underpin immigration detention. Even if a boycott were to achieve more immediate change, would this be sustainable if there were still majority public and political support for immigration detention?

Another issue that has been briefly discussed relates to the impact a boycott may have on those detained. Withdrawing services may only further adversely impact
the health and wellbeing of those detained. While such action should therefore be given careful consideration, there is good reasons to suggest it would have minimal impact. All evidence indicates that current healthcare arrangements are ineffective, furthermore, evidence that has examined the impact of strikes in other healthcare settings suggests that if services are removed carefully and emergency staff remain in place, there are likely to be few adverse impacts on patients (Cunningham et al. 2008; Metcalfe et al. 2015; Ruiz et al. 2013).

In summary, current engagement with Australian immigration detention cannot be justified on balance. A boycott may therefore be justified if it does not disproportionately impact those detained. Even so a boycott is not the only action that should be taken. Consideration also needs to be given to how remaining clinicians within immigration detention should be supported, along with how to engage with the broader social and political factors that underpin and re-enforce Australian immigration detention. These are complex issues and call for a collective, cooperative response from all clinicians and healthcare bodies. Action is needed to motivate change as urgently as ever.

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Healthcare and clinical ethics in Australian offshore immigration detention

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Part of Australia’s ongoing efforts to deter asylum seeker boat arrivals, offshore immigration detention has been widely criticised since its reintroduction in 2012. These environments undermine the principles that would normally drive clinical and ethical decision-making, resulting in circumstances that are uniquely problematic and compromising. In addition to the more general complaints about Australia’s policy of mandatory immigration detention, riots, violence, abuse, self-harm and a number of deaths have been reported in offshore centres. Centring on a number of recent inquiries, this article provides a review of the literature, focusing on the uniquely problematic issues faced in Australia’s offshore immigration detention centres.

Keywords: refugees; asylum seekers; clinical ethics; immigration detention; healthcare

Introduction

Australia has had a policy of mandatory immigration detention in place since 1992. During this time offshore processing has been introduced, repealed and re-introduced. The most recent offshore processing regime was introduced in mid-2012 and initially did little to deter boat arrivals. In mid-2013 the government announced that asylum seekers who arrived by boat would be transferred to Manus Island (Papua New Guinea) or Nauru and given no opportunity to resettle in Australia. Both major political parties also supported a policy of towing back asylum seeker boats. This policy has generally been conducted in secrecy, however the government more recently revealed it had resulted in the turning back of 20 boats, carrying over 633 asylum seekers in the last 18 months to August 2015.

As of July 2015 there were 1600 people being held in offshore immigration detention (655 on Nauru and 945 on Manus Island) including 88 children being held on Nauru. There were also 173 people being held on Christmas Island, a remote Australian territory approximately 2600 km north-west of Perth. These numbers are significantly lower than previous years, for example, as of July 2014 there were 2273 people being held in offshore immigration detention facilities, including 183 children. There were also 1004 people, including 148 children being held on Christmas Island and alternate places of detention on the Cocos Keeling Islands.

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Offshore immigration detention has been a particularly contentious issue amongst a set of already highly controversial and criticised policies. More generally, Australia’s approach to asylum seekers has been described as ‘uniquely draconian’\(^7\) and ‘state sponsored abuse’.\(^8\) Other more general criticisms have ranged from breaching human rights and international law,\(^9\) having a damaging and long-term impact on mental health,\(^10\) including epidemic rates of self-harm\(^11\) and being responsible for multiple deaths.\(^12\) Offshore immigration detention further exacerbates these issues and creates a range of new concerns. This has been reflected in disturbing reports of self-harm, riots, violence, physical and sexual abuse and deaths since its re-introduction.\(^13\)

### Healthcare delivery and offshore immigration detention

The arrangements for healthcare in offshore immigration detention are similar to those found across the broader immigration detention network. International Health and Medical Services (IHMS) provide services on site, while local hospitals and other contracted allied health professionals are utilised to provide ancillary and specialist services. de Boer\(^14\) provides a broad overview of these arrangements:

The provision of health care to asylum seekers on Nauru and Manus Island is governed by the ‘Heads of Agreement’ between the Commonwealth of Australia (represented by the Department of Immigration and Citizenship (DIAC)) and International Health and Medical Services (IHMS) (the contract). The contract was tabled in the Senate on 21 September 2012, with the payment schedule and financial details redacted. Despite this, some financial details are known, such as that IHMS will be paid $22 million for the provision of health care for six months from 14 December 2012. The contract was not published online and is only available from the Senate Table Office. In the absence of an online document, this background note will set out the key clauses of the contract and examine their adequacy in providing for the mental and physical health needs of asylum seekers being detained in RPCs.

The healthcare arrangements across the detention network have been spoken about elsewhere,\(^15\) however contractual and administrative arrangements in offshore centres appear largely to be similar to those onshore. The main objectives of the contract between the immigration department and IHMS are to provide healthcare services to asylum seekers on Nauru and Manus Island that are:

- ‘open, accountable and transparent’ and
- to a ‘standard and range of health care that is the best available in the circumstances, and utilising facilities and personnel on Nauru and Manus Island’ and ‘that as far as possible (but recognising any unavoidable limitations deriving from the circumstances of Manus Island and Nauru) are broadly comparable with health services available within the Australian community’.\(^16\)

During the recent Parliamentary Inquiry\(^17\) both the immigration department and IHMS re-affirmed that the services they provide are ‘broadly comparable’ with services provided in the Australian community:

IHMS employs doctors, nurses, psychologists, counsellors and administrators as well as other specialist health care professionals to ensure that, as far as possible, the health care services received by Transferees are broadly comparable with that available in the Australian community. This means that transferees are reviewed at first by a nurse. They will give advice and treatment, or they may refer the Transferee to a doctor or other health care professional if
required. If required, the Transferee makes an appointment to see a member of the health staff during the published clinic hours for any routine or non-urgent matters. If the matter is urgent the transferee will be seen more quickly or immediately. If the Transferee is referred to another health care professional, there is a waiting period which may be up to several weeks or longer.18

**Method**

The remainder of this article will discuss major themes emerging from the literature that illustrate the uniquely problematic and damaging nature of offshore detention. A critical interpretive review has been utilised to achieve this.19

The focus of this article will be detention centres on Manus Island, Nauru (since their re-opening in mid-2012) and Christmas Island. Although Christmas Island is an Australian territory and notably different from the facilities on Nauru and Manus Island, for example it has purposely built permanent infrastructure,20 it appears appropriate to include in this review as it has a number of parallels to other offshore environments and raises similar issues in regards to the delivery of healthcare. It should also be noted that although at the time of writing children only remain on Nauru, for many years prior children were also detained on Christmas Island.

A number of major reports and investigations will form the foundation of this article so it is worthwhile outlining them here:

- The Christmas Island Medical Officer’s Letter of Concern.21 This letter was written by 15 doctors, all of whom worked on Christmas Island. It was subsequently given to The Guardian Australia. This letter outlines a number of issues related to the delivery of healthcare on Christmas Island in 2013.
- The Cornall Review, including a more detailed report obtained by The Guardian Australia which was not publicly released.22 This independent review was commissioned to investigate allegations of assault and a riot on Manus Island in February 2014, which resulted in the death of an asylum seeker and other major injuries.
- Report by the Physical and Mental Health Subcommittee of the Joint Advisory Committee for Nauru Regional Processing Arrangements.23 This report was obtained by The Guardian Australia and was originally intended to be confidential. It provides an assessment and recommendations regarding the health of people held in detention on Nauru.
- The Australian Human Rights Commission (AHRC), Forgotten Children: National Inquiry into Children in Immigration Detention Report.24 With increasing numbers of children being detained and ten years on from the original Human Rights and Equal Opportunity Commission report25 the AHRC conducted this inquiry to investigate human rights issues, Australia’s international obligations and the ways in which immigration detention affected the health, well-being and the development of children.
- The Moss Review.26 This independent review was commissioned to examine allegations of physical and sexual abuse and the conduct of staff on Nauru.
- The Australian Parliamentary Select Committee on the recent allegations relating to conditions and circumstances at the Regional Processing Centre in Nauru.27 The Australian Senate established the Select Committee in early 2015 to investigate the circumstances on Nauru, including the ongoing allegations of physical and sexual abuse following the Moss Review and AHRC investigations.
Treatment and transfers

Although IHMS provides healthcare within offshore immigration detention centres, local hospital services are still relied upon for specialist and allied healthcare. These services are however very limited, with the Australian Parliamentary Select Committee\(^28\) advised that steps were being taken to upgrade health services on Nauru, with priority placed on services such as MRI and CT scanning capabilities and a full-time obstetrician. Procter et al.\(^29\) provide this description of the Nauru hospital:

> Conditions at the hospital are difficult, particularly following the 2013 fire. There is no bed linen (patients families usually provide this when they are admitted), there are limitations with infection control procedures, the medical incinerator has not been functioning for some time, and the buildings have structural issues, including the use of asbestos sheeting. Visiting medical specialists are asked to bring their own equipment and supplies, including drapes. There is limited availability of medical evacuation due to cost, and commercial flights are used when care overseas (typically in Australia or Fiji) is needed for Nauruan citizens; the example given was in complicated pregnancies. The medical records office was destroyed in the August 2013 fire.

Similar concerns were raised on Christmas Island, with the AHRC\(^30\) noting that the hospital provided ‘basic in-patient services as needed’ and that there remained very little access to specialist care. These limitations result in a need to transfer individuals to the Australian mainland for treatment for more complex or serious conditions.\(^31\)

In practice, transfers to the Australian mainland for treatment have been problematic, with numerous examples emerging where treatment recommendations have not been acted upon in a reasonable timeframe, dismissed or ignored. This has already resulted in tragedy, as was the case with Hamid Kehazaei who initially developed a skin infection which subsequently worsened to septicemia. After a delayed transfer from Manus Island he was pronounced dead in a Brisbane hospital.\(^32\)

Other recent incidents have included alleged sexual assaults, where the clinical advice of healthcare staff was not followed. The Cornall Review (specifically the more detailed report, not publicly released, obtained by The Guardian Australia)\(^33\) quotes a medical officer who made recommendations in regard to an alleged victim of sexual assault: ‘Our preferred choice was to have him flown off the island or accommodated in a separate compound away from the perpetrators.’ This advice was overruled by the immigration department, which stated, ‘Mr A had to [sic] treated on the island and moved out of [redacted] and returned to the single adult male compound as soon as possible.’ These issues do not appear to be isolated and appear to be ongoing, with the Australian Parliamentary Select Committee\(^34\) receiving submissions about an alleged incident in May 2015, where a female asylum seeker had been sexually and physically assaulted. Evidence put to the committee suggested a transfer to Australia was recommended, but initially denied by the immigration department. It was not until August 2015 that the immigration department advised that the individual had been taken to Australia for treatment.

Similar concerns were also raised in the Christmas Island Medical Officer’s Letter of Concern\(^35\) in relation to transfers between centres from Christmas Island to Manus Island and Nauru, with individuals being transferred prematurely, before appropriate health assessment could be carried out, in response to the policies of the immigration department.

Those who are transferred, whether to mainland Australia or hospital, are likely to be returned to detention, often the same environment that has initially contributed to their poor health. A document obtained by the Human Rights Law Centre and reported upon by The Guardian Australia reveals internal emails from the immigration department
calling for people to be returned to Manus Island and Nauru ‘as soon as possible’, fearing they would join a legal challenge. A recent example of this came when the immigration department defied advice not to return an infant to Nauru from the Australian mainland. The dilemma this creates for clinicians has been discussed by Zion et al.:

Furthermore, when severely ill patients were referred to psychiatrists or to hospitals outside the detention setting, they generally were returned to detention when their condition improved, only to become ill again. This presented psychiatrists and other mental health care practitioners with a serious role conflict, as their recommendations and treatment only served to make the detention system workable by temporarily removing patients who were at great risk and shielding the terrible conditions of detention from public accountability.

These issues are part of a larger systemic problem in Australian immigration detention, namely that clinical independence is frequently compromised and healthcare is often subverted for other objectives. The literature has already detailed countless instances where clinical recommendations have not been followed at all, delayed or dismissed; however, transfers from offshore detention appear to be particularly problematic. In testimony to the Nauru Senate Inquiry, the former medical director of IHMS, Peter Young, stated that the immigration department interfered regularly with clinical advice and that recommendations would often be challenged. When the approval to fly from an offshore location is determined by the immigration department, a significant amount of power is taken from clinicians in determining how treatment is delivered. This is one particularly damaging aspect of the broader disempowerment of healthcare in these environments.

The offshore environment and its impact

‘The difference between Villawood and Nauru was like the difference between an angel and a devil.’ A family who had been transferred from Nauru to Villawood, quoted in Isaacs.

The offshore immigration detention environment, particularly on Manus Island and Nauru, appears to be significantly more damaging than that found in onshore immigration detention centres. Numerous inquiries, reports and articles have now raised concerns about the detention environment and the issues this creates in delivering healthcare. One of the many descriptions of Nauru by the AHRC is as follows:

Nearly every first-hand account of Nauru makes reference to its overwhelming heat… Offshore Processing Centre is the name of the camp where children and families are housed on Nauru. It is a gravel construction site. The tent accommodation is situated on loose and uneven rocks. Parents expressed concern that thongs wear out ‘almost immediately on the gravel’ and children described walking and running in the centre as ‘painful’.

The Australian Parliamentary Select Committee Report gave further insight into these conditions. Poor, crowded living conditions, limited access to water, facilities beyond repair and exposure to phosphate dust were all raised as issues. Mice, rats and other pests such as mosquitos were noted. The parallels between the conditions in these centres and those of prisons were raised, including the use of a point system, standardised meal times and shower times. After a visit to Nauru, Amnesty International described the conditions there as ‘squalid’.

A theme throughout the Moss Review and Australian Parliamentary Select Committee Report related to lack of privacy and the impact this had on mental health and relationships. Both inquiries also discussed a lack of protection and safety for individuals in these environments, with the Moss Review noting that many people were apprehensive about
their personal safety. As a result of this, the Moss Review concluded that it was likely that abuse was being underreported. Conditions appear to be nearly identical on Manus Island.\textsuperscript{49} In addition to the physical environment, physical and sexual violence appear to be widespread, with riots, self-harm, suicide attempts and assaults repeatedly reported on Manus Island.\textsuperscript{50} Issues related to physical and sexual assault will be discussed in more depth below.

Although conditions appear to be comparatively better on Christmas Island, the AHRC\textsuperscript{51} was still critical of the use of this centre and raised a number of deficiencies, it is also notable there have been riots, violence and unrest on Christmas Island as well.\textsuperscript{52} The Christmas Island Medical Officer’s Letter of Concern\textsuperscript{53} identified numerous deficiencies and shortcomings in relation to the delivery of healthcare, including medication shortages, equipment shortages and limitations in relation to medical facilities:

- Facilities are not fit for purpose and medical supplies are poorly managed with frequent shortages impacting on clinical care. The dispensation and prescription of medications are performed in an unsafe and substandard manner. An ineffective electronic health system with multiple errors, each of which constitutes a significant risk to patient safety. The processes are not intuitive and present a prohibitive administrative burden.\textsuperscript{54}

The Christmas Island Medical Officer’s Letter of Concern also raised a number of issues that appear to be unique to the reception of asylum seeker boat arrivals, including inadequate procedures that compromise patient dignity, capacity to consent to treatment shortly after arrival and the loss and destruction of medications that asylum seekers carry with them. Conditions related to healthcare appear to be significantly worse on Nauru, with numerous deficiencies and inadequacies noted throughout recent investigations, including slow and inadequate care, a culture of scepticism and mistrust and the use of an individual’s boat number as identification rather than their name.\textsuperscript{55}

The impact these environments have on health also appears to be dramatically worse than the impact onshore detention has. Offshore environments raise a host of other issues, including public health concerns, which are not found in onshore detention, these include restricted access to water, poor hygiene, mould and mosquito-related illness; among other issues this creates a higher risk for communicable disease outbreaks. There was also noted to be the lack of any formal strategy to deal with these potential public health issues.\textsuperscript{56} Furthermore the impact that these environments have on mental health is devastating. This was expressed a number of times throughout the Australian Parliamentary Select Committee\textsuperscript{57} with a former staff member stating:

> I think it would be fair to say that, in the regional processing centre, we are dealing with a range of incredibly traumatised people who are often extremely stressed. I think conditions of hardship where tent conditions are hot, where there is a lack of privacy and where you may not be able to sleep contribute to stress and I think makes a situation where self-harm or other types of antisocial behaviours are very possible. So I do think it is a contributing factor.\textsuperscript{58}

Delivering treatment in immigration detention has long been recognised as problematic and even, to some degree, futile.\textsuperscript{59} This is no more obvious than in offshore immigration detention, with the environment having a devastating impact on healthcare delivery. At best the detention environment provides a ‘socially impoverished and artificial’ environment that has a significant impact on the ‘mentally ill person re-establishing his or her social identity and functioning’, \textsuperscript{60} and at worst, they actively promote suffering as a means of deterrence.\textsuperscript{61} The major issue becomes how to best deliver treatment and maximise outcomes in an environment that actively works against health and well-being. As Coffey discusses,\textsuperscript{62} it may in fact be
more productive for clinicians to put their time into negotiating with the department and providing basic services and advocacy rather than more orthodox clinical interventions.

**Physical and sexual assault**

Particularly disturbing allegations to have come from recent investigations relate to the widespread physical and sexual assault of both adults and children in offshore detention. The Moss Review\textsuperscript{63} uncovered two allegations of rape of adult female individuals on Nauru, one of which was reported to the Nauru Police. This review also discusses a number of other allegations of indecent assault, sexual harassment and physical assault, some allegedly perpetrated by staff. It also concludes that there was a level of underreporting, generally for family or cultural reasons but also due to concerns about the consequences of reporting complaints, or due to a belief that nothing would be done. As was already discussed, a common theme throughout the Moss Review and the Australian Parliamentary Select Committee Report\textsuperscript{64} related to the privacy and personal safety of asylum seekers. The parliamentary inquiry also detailed a number of submissions it received alleging abuse after the Moss Review, including sexual harassment, sexual exploitation and threats of sexual violence. The inquiry reiterated that the living conditions, particularly for women and children, were unsafe and that they increased the likelihood of abuse. Similar allegations of abuse were made on Manus Island and although the Cornall Review\textsuperscript{65} was not able to substantiate these claims, the detention environment, lack of legal protection for detainees, along with the underreporting of abuse, as noted in the Moss Review\textsuperscript{66} continues to make for an environment that makes abuse more likely to occur. The environment created by offshore detention worryingly has a number of parallels to environments in which abuse has occurred in the past, as Peter Young\textsuperscript{67} discussed during the Australian Parliamentary Select Committee:

\begin{quote}
Wherever there is a situation in an institution where there is a vulnerable group that is under supervision, and where there is a power differential between those who are being supervised and those who are supervising them, you create the conditions in which abuses tend to occur. The other factor that adds to that, in this situation particularly, is when there is non-transparency and when there is a lack of capacity for independent oversight. The final thing that really has a very powerful effect – and we have seen this in other institutions where abuse has occurred very regularly – is when there is this overriding concern that the interests of the institution, the preservation of the institutional interests, override everything else. We have seen this in the current royal commission that is occurring in relation to the reputation and the wealth of organisations overriding the concerns of duties of care, and we see it in this example where the policy position of stopping the boats and maintaining the offshore processing facility and its reputation is the overriding concern.
\end{quote}

The process of dealing with reports of sexual assault was also noted as grossly inadequate. As a former staff member noted in the Australian Parliamentary Select Committee Report\textsuperscript{68}:

\begin{quote}
The process in Australia is that, when someone reports a sexual assault, they would initially be taken to a hospital, usually, and there would be a forensic examination offered. When they arrive at the hospital they would meet with a qualified social worker or psychologist who would provide assistance, support and crisis counselling in relation to the event of the assault. Then a specialist unit that investigates sexual assault would be called in if they wanted to follow through with a forensic examination. That is just not available in Nauru. Following that, most victims would be offered ongoing sexual assault counselling. Again, that is not available in Nauru.
\end{quote}

Alarmingly, abuse was not reported by the immigration department, having known about a number of cases of abuse as early as December 2013, well before it launched the Moss
Review in September 2014 to investigate these claims. At the public hearing for the parliamentary inquiry the secretary of the immigration department confirmed that the department had received incident reports as early as September 2012 that indicated alleged abuse.

**Children in offshore detention**

Children have been detained on Christmas Island for many years and on Nauru since its reopening in 2012. As noted above, as of July 2015 there were 88 children being held on Nauru. Children being held in immigration detention are a particularly vulnerable group that deserve special attention and protection. Although similar issues are faced in onshore detention, like many of the concerns raised in this article, the situation for children appears even more fraught in regard to offshore detention. This issue has been spoken about extensively elsewhere and has been central to many recent investigations, it is for this reason only discussed briefly here. The AHRC Forgotten Children Report heard damming testimony, and concluded, among other things, that ‘[t]he mandatory and prolonged immigration detention of children is in clear violation of international human rights law’, with immigration detention having ‘profound negative impacts on the mental and emotional health of children’. The AHRC inquiry, along with the Moss Review and the Australian Parliamentary Select Committee paint a bleak picture. As a whole, they detail alleged widespread abuse of children, epidemic levels of self-harm and suicide attempts, extreme levels of distress, the breakdown of families, and frequent exposure of children to extreme violence. The Physical and Mental Health Subcommittee Report discussed a number of issues related to healthcare and children on Nauru and noted numerous deficiencies surrounding transfers for medical treatment, limited independent oversight, a lack of screening and gaps in immunisation provision. Even on Christmas Island the issue of providing healthcare for children was criticized, with the Christmas Island Medical Officer’s Letter of Concern discussing a lack of specialist care leading to the ineffective management and treatment of children. Many of the conclusions reached in these investigations, such as the harm caused by immigration detention, have been long known, previously coming to light after the original Human Rights and Equal Opportunities Commission (HREOC) Report.

Dealing with child protection on Nauru is particularly problematic, not just because of the impact of the environment, but also because there are no clear legal protections or child protection framework. Given the widespread abuse already reported on Nauru and the governments increasing secrecy and history of denying or not reporting abuse (which will be discussed below) this is alarming. It is also worthwhile noting that for unaccompanied children, the minister of the immigration department becomes their carer once detained. The obvious conflict here was raised in the Physical and Mental Health Subcommittee Report which questioned how decision-making around children and acting in their ‘best interests’ may occur. Examples of the issues this creates could be found throughout the Australian Parliamentary Select Committee Report with a former clinician discussing not only the impact that detention has, but their inability to manage this situation and take adequate steps to protect children:

> Despite intensive case management services, this mother’s mental health was so poor that she later threatened to kill herself and her two children. The child protection and support worker assessed the risk posed to this child as serious however DIBP did not remove him from detention. Instead, they directed a Commonwealth contractor (SCA) to develop a ‘safety plan’ for this child as he would be required to remain in the care of his mother.
Secrecy, oversight and offshore detention

The long-standing culture of secrecy surrounding immigration detention has been promoted with a number of recent measures aimed at reducing oversight and transparency, with a particular emphasis on offshore environments. Already isolated, access to journalists was tightened on Nauru. There have also been numerous attempts by the government to silence and discredit critics. An example of this came after a number of former employees signed an open letter alleging the government knew about allegations of abuse on Nauru for 17 months and did not take any action. Staff who made the accusations were attacked by the government but then later vindicated by the Moss Review which found a number of these allegations credible. Another example came after the release of the AHRC Forgotten Children Report, which was highly critical of the government’s detention of children. After its release, the government went on the offensive with a number of attacks on the president of the AHRC, Gillian Triggs. More recently, multiple raids were carried out on Save the Children’s offices in Nauru in an attempt to find journalists’ sources on the island. These measures have followed the disbandment of the Immigration Health Advisory Group, one of the only bodies that provided independent oversight of health and healthcare. During the Australian Parliament Select Committee a former employee described

’a culture of silence and cover up and a lack of accountability in the Nauru RPC’, describing as one example an incident where a Nauruan security guard aggressively confronted an asylum seeker in the presence of himself along with a number of other security guards, but the other security guards did not endorse his reporting of the incident, in what he described as ‘a collaborative attempt to blame the asylum seeker rather than the Nauruan guard.

One of the most controversial aspects of the government’s policy and an unprecedented step towards increasing secrecy was the Border Force Act. This legislation makes it an offence, punishable by two years in prison, for any current or former employee to record or disclose ‘protected information’. This broadly worded piece of legislation includes any information obtained whilst working in immigration detention. The introduction of the Border Force Act leaves clinicians powerless to speak out about abuse that may be ongoing and/or inadequately addressed without risking time in gaol. Although there remain narrow provisions to report abuse and other matters of public interest, it is an area of law that remains complex and untested and still effectively only allows clinicians to report to the immigration department, in many cases directly to the abuser.

The inadequacy of current reporting systems and accountability makes this even more concerning, with these issues being raised in the Moss Review, noting that once avenues within the centre have been exhausted, issues may not be escalated, actioned appropriately or in a timely manner. Also raised throughout the Australian Parliamentary Select Committee were that complaints procedures were inadequate for this very reason, that contractors investigated their own behaviour. A former employee stated:

The above systems created an environment where both asylum seekers and SCA staff were intimidated to not take action against security services. Asylum seekers held the valid fear that if they received refugee status and entered the community there would be retribution from Nauruan security officers. Asylum seekers were aware that it was possible that any complaint they made against a security officer could be seen by that person.

Responses to offshore immigration detention

Professional healthcare bodies in Australia have long been opposed to Australian immigration detention. They have issued numerous position statements and long condemned
the government’s position in relation to mandatory immigration detention. Like other responses to criticism and previous research, the government has dismissed or attempted to discredit those opposed to these policies. This has placed professional bodies in a position where advocacy and reasoned argument have failed. It was not until more recently that there has been a discussion in relation to collective action, more specifically clinicians boycotting Australian immigration detention. This was addressed at the recent Australian Medical Association (AMA) forum on the Health of Asylum Seekers. Despite acknowledging the devastating impact of immigration detention and that it amounted to a ‘state-sanctioned form of child abuse’ the AMA dismissed a boycott asserting that by working in immigration detention clinicians were not complicit in wrongdoing, rather they were simply placing patients first and that if any change should come, it should be through the weight of public opinion. The AMA instead called for the immediate release of all children along with a moratorium on asylum seeker children being returned to immigration detention. They also called for an independent body of experts to be re-established to report on the welfare of asylum seekers and refugees, and furthermore, that if satisfactory healthcare could not be provided, the governments ‘policies should be revisited’. Others have called for health services to be returned to state health agencies to address many of the above issues and increase transparency.

The increasingly regressive measures taken by the government have also been met with increasing resistance from clinicians. In response to the Border Force Act, over 40 former immigration detention employees, including a number of clinicians, signed an open letter challenging the government to prosecute; many others have continued to speak, despite risking prosecution and protests have been staged across Australia. This has even lead clinicians into what could be called civil disobedience. The case of baby Asha is illustrative of this, a case where doctors refused to discharge an infant if she was to be returned to immigration detention on Nauru. This lead to a standoff with the immigration department until a compromise was reached and the family was released into community detention. Despite this, the immigration department maintained the family would eventually be returned to Nauru.

Conclusions

Already one of the most problematic environments in Australia (or more precisely under Australia’s control), offshore immigration detention amplifies existing issues and creates additional challenges even in comparison to already compromising immigration detention centres on the Australian mainland. Offshore detention provides the most obvious example of the transformation of clinical and ethical decision-making in these environments. Healthcare is disempowered, with the principles that usually underpin decision-making absent or distorted. For clinicians many of the dilemmas faced in offshore immigration detention centres are around how best to manage individuals in an abusive environment where there is little or no specialist care available. Over the last three years, offshore detention centres have seen epidemic rates of self-harm and suicide attempts, widespread physical and sexual abuse and violence and riots. Options beyond basic services are limited, with the department intervening frequently to limit the discretion of clinicians and transfers to what would otherwise be safe locations, either offshore or on the mainland. For children in detention, there remains little protection, with no child protection framework on Nauru, something that is particularly concerning given the now well-documented physical and sexual abuse. This all occurs with little oversight and increasing secrecy, with clinicians who speak about any
aspect of their time working in detention risking up to two years in gaol. What is clear and perhaps more so in offshore immigration detention is that very little can be achieved clinically within the current constraints of the system. If change is to be realised, collective political action is needed, something called for years earlier by McNeil.\textsuperscript{103}

It is claimed that when governments are immune to human suffering there is a moral justification and a role for health professionals taking political action. These actions may go beyond dissemination of information and reasoned advocacy, and could include any number of political activities including: participating in demonstrations, direct lobbying of government members and political parties, and withdrawal of services. The justification for engaging in these activities lies in a moral obligation to oppose inhumane treatment and a recognition that reasoned argument may be insufficient.

A discussion about healthcare in immigration detention and whether clinicians’ involvement can be justified is one that should be ongoing. While a boycott appears to be one of many options in moving towards addressing the myriad issues discussed above, offshore detention and the continually regressive measures implemented by the government continue to make this more appealing.

**Disclosure statement**

The author previously worked for the Australian immigration detention healthcare provider, International Health and Medical Services as a Counsellor from 2011–2015.

**Note on contributor**

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**Notes**


16. Ibid., 14.


18. Ibid., 80.


26. Moss, ‘Review into Recent Allegations Relating to Conditions and Circumstances at the Regional Processing Centre in Nauru’.
27. Australian Parliamentary Select Committee, Taking Responsibility.
28. Ibid.
33. Farrell, ‘Not Seen, Not Heard’.
34. Australian Parliamentary Select Committee, Taking Responsibility.
35. Christmas Island Medical Officer’s Letter of Concern.
40. Farrell, ‘Not Seen, Not Heard’.
43. Australian Parliamentary Select Committee, Taking Responsibility.
45. Moss, ‘Review into Recent Allegations Relating to Conditions and Circumstances at the Regional Processing Centre in Nauru’.
46. Australian Parliamentary Select Committee, Taking Responsibility.
47. Moss, ‘Review into Recent Allegations Relating to Conditions and Circumstances at the Regional Processing Centre in Nauru’.
49. Cornall, ‘Review into the Allegations of Sexual and Other Serious Assaults’; Cornall, ‘Review into the Events at the Manus Regional Processing Centre’.
52. Christmas Island Medical Officer’s Letter of Concern.
53. Ibid., 4.
57. Australian Parliamentary Select Committee, Taking Responsibility.
58. Ibid., 63.
60. Coffey, ‘“Locked up without Guilt or Sin”’.
62. Coffey, ‘“Locked up without Guilt or Sin”’.
63. Moss, ‘Review into Recent Allegations Relating to Conditions and Circumstances at the Regional Processing Centre in Nauru’.
64. Australian Parliamentary Select Committee, Taking Responsibility.
65. Cornall, ‘Review into the Allegations of Sexual and Other Serious Assaults at the Manus Regional Processing Centre’.
66. Moss, ‘Review into Recent Allegations Relating to Conditions and Circumstances at the Regional Processing Centre in Nauru’.
68. Ibid., 100.
69. Ibid.
72. Ibid., 29.
73. Moss, ‘Review into Recent Allegations Relating to Conditions and Circumstances at the Regional Processing Centre in Nauru’.
74. Australian Parliamentary Select Committee, Taking Responsibility.
76. Christmas Island Medical Officer’s Letter of Concern.
77. Human Rights and Equal Opportunities Commission, A Last Resort.
81. Australian Parliamentary Select Committee, Taking Responsibility.
82. Ibid., 108–09.
85. Moss, ‘Review into Recent Allegations Relating to Conditions and Circumstances at the Regional Processing Centre in Nauru’.


90. Australian Parliamentary Select Committee, Taking Responsibility, 125.


93. Moss, ‘Review into Recent Allegations Relating to Conditions and Circumstances at the Regional Processing Centre in Nauru’.

94. Australian Parliamentary Select Committee, Taking Responsibility, 38.


A Community Standard: Equivalency of Healthcare in Australian Immigration Detention

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Abstract The Australian government has long maintained that the standard of healthcare provided in its immigration detention centres is broadly comparable with health services available within the Australian community. Drawing on the literature from prison healthcare, this article examines (1) whether the principle of equivalency is being applied in Australian immigration detention and (2) whether this standard of care is achievable given Australia’s current policies. This article argues that the principle of equivalency is not being applied and that this standard of health and healthcare will remain unachievable in Australian immigration detention without significant reform. Alternate approaches to addressing the well documented issues related to health and healthcare in Australian immigration detention are discussed.

Keywords Refugees · Asylum seekers · Clinical ethics · Immigration detention · Healthcare · Equivalency

Healthcare in Australian Immigration Detention and the Detention Health Framework

Australia’s policy of mandatory immigration detention is now close to 25 years old. Since its introduction adult and child asylum seekers and refugees have been detained for prolonged and occasional indefinite periods of time. While Australia has managed centres on the mainland consistently, a policy of offshore processing was re-introduced in 2012, with centres now on Manus Island (Papua New Guinea) and Nauru. Although initially having little impact on deterring an increasing number of boat arrivals, in 2013 the government announced that any asylum seekers who arrived by boat would be given no opportunity to resettle in Australia. As of December 2015, 537 individuals were detained on Nauru, including 68 children, 922 on Manus Island and 1792 in mainland detention, including 91 children [1]. These numbers are significantly lower than previous years, for example, prior to the introduction of offshore processing there were 9256 individuals detained in mainland immigration detention centres, including 1820 children [2]. While policies of mandatory immigration detention have long been controversial many issues appear to be made more acute by offshore detention with dehumanising conditions, riots, violence, self-harm, suicidal behaviour and widespread physical abuse of both adults and children already reported [3–6]. Another major and persistent criticism has been related to health and healthcare. The Detention Health Framework [7] was established in 2007 following the wrongful detention and deportation of Australian citizens and permanent residents [8, 9]. This framework outlines the principles and aims of healthcare in Australian immigration detention. The key outcomes of the Detention Health Framework are to ensure that:

- the Department’s policies and practices for health care for people in immigration detention are open and accountable;
- people in immigration detention have access to health care that is fair and reasonable, consistent with Australia’s international obligations and comparable to those available to the broader Australian community; and
• ensure that quality of health services provided to people in immigration detention is assured by independent accreditation.

Other aspects of this framework include the aim that wellbeing should only be impacted by restriction of movement, or in other words, “the least restriction of freedom possible within the constraints of detention under the Migration Act 1958” [7].

International Health and Medical Services (IHMS), a private healthcare company, have held the contract to deliver healthcare within immigration detention since 2007. These services are supplemented by local hospitals and other contracted health professionals. The mission statement for IHMS states that among other services they will deliver healthcare to a standard that is consistent with that found in the broader Australian community, while taking into account the diverse and complex health needs of those detained [10]. Many of these principles and goals have been re-affirmed over the years by both the immigration department and IHMS, particularly the principle that healthcare is delivered to a standard equivalent with the broader Australian community. This was discussed during the 2012 Joint Select Committee on Australia’s Immigration Detention Network by Ian Gilbert, the then General Manager of IHMS who stated that [10]:

If you go back to the original philosophy of the contracted service, it was very much around primary healthcare at a community equivalent standard. At a site like Villawood [A detention centre located in NSW, Australia], for example, which was an originally contracted site, that is very much the philosophy in play. And you are correct; if there is an incident or a medical question that needs to be asked after hours, then we do have a telephone service that is answered by nurses…. It is stipulated in the contract that they are not only in accordance with the timeframes as stipulated by the document itself but also to offer a community equivalency level of care. But in saying that there is also a capacity to extend and be flexible. That is an ongoing dialogue that could happen locally on the ground between the local management teams to extend hours, if it is a short-term requirement. Or equally, through discussion with our Canberra colleagues, to adjust the service delivery model more permanently.

This was again re-enforced in the more recent Senate inquiries into detention on Manus Island and Nauru with healthcare noted to be “very similar to a community mental health service in Australia” [6] on Manus Island and “broadly comparable with health services available within the Australian community” [3] on Nauru.

The assertion that healthcare in Australian immigration detention centres is provided to an equivalent found in the broader Australian community has been a persistent one, it is also a claim that has gone largely unexamined. However even on face value it appears to be an oversimplification and in sharp contrast with the well documented health outcomes and realities of delivering healthcare to people in immigration detention. Before examining this more closely it is worthwhile discussing the prison healthcare literature, an area where the idea of equivalency has received more attention.

**Equivalency in Prison Healthcare**

The principle of equivalency can be found throughout international and national guidelines in relation to prison healthcare [11]. Although definitions vary they largely converge on a prisoner’s right to have the same standard of healthcare that is received in the broader community. This principle was first adopted by the United Nations General Assembly resolution 37/194 in 1982. It can also be found in the United Nations Basic Principles for the Treatment of Prisoners, Principle 9 [12] and the World Health Organisations Guide to Essentials in Prison Health [13]. In Australia this principle can be found in the Australian Institute of Criminology Standard Guidelines for Corrections [14]:

Every prisoner is to have access to evidence-based health services provided by a competent, registered health professional who will provide a standard of health services comparable to that of the general community. Notwithstanding the limitations of the local-community health service, prisoners are to have 24-hour access to health services. This service may be on an on-call or stand by basis.

The Australian Medical Association appear to have gone further in their position statement on health and the criminal justice system, acknowledging that the prison population is in many ways a vulnerable population, often with more complex healthcare needs:

- prisoners and detainees have the same right to access, equity and quality of health care as the general population … health services in custodial settings should be resourced and designed to provide a level of care that is commensurate with the health needs of prisoners and detainees and should accommodate the diverse and complex needs of vulnerable and highly disadvantaged subgroups [15].

Despite its prevalence in Australian and international policy, guidelines and position statements this principle has
also received criticism which can be divided into clinical, conceptual and environmental concerns [11]. Conceptual issues include how this principle has been applied and measured, for example equivalence generally does not take account of the outcomes related to care, rather the process of care itself. As Charles and Draper [16] note, “considerably different health outcomes may result from equivalent process in dissimilar populations”. More fundamentally issues such as what good health means in prison [11] and the complexities of how to best achieve this are often overlooked:

The WHO suggest the aim of policy for equity in health is ‘not to eliminate all health differences so that everyone has the same level and quality of health, but rather to reduce or eliminate those which result from factors which are considered to be both avoidable and unfair’. The principle of equivalence should therefore be implemented so as to reduce ‘avoidable or unfair’ health differences between the prisoner population and general population, while at the same time aspiring to meet the United Nations International Covenant on Economic, Social and Cultural Rights, which affirms ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ [16]

The principle of equivalency also raises a range of clinical issues, often failing to take into account the realities that are unique to delivering healthcare in prison including the vulnerabilities of the population, the complex and clashing objectives between healthcare and prison management and the impact of the prison environment itself [17]. So while there is a need for conceptual clarity, there is also a need to take into account the complexities of delivering healthcare in prison environments and the vulnerabilities of the prison population, including the significantly poorer health outcomes amongst this population. Other remaining questions include how to best define and operationalise equivalency in these environments and if it is in fact even a helpful principle.

**Equivalency of Healthcare and Australian Immigration Detention**

Similar questions could be asked of equivalency in relation to Australian immigration detention. Despite the government’s insistence that healthcare is provided to a standard found in the broader community this remains poorly explained and little has been done to explore these claims or extract further clarification as to how this standard is operationalised and measured. It does however seem to contradict not only the devastatingly poor health outcomes seen in Australian immigration detention, but the well documented cases of sub-standard care, limited oversight and secrecy, breaches of confidentiality and the involvement of the government in healthcare. This will be discussed in more depth below with the remainder of this article examining [1] whether the principle of equivalence is being applied in Australian immigration detention and [2] whether this standard of care is achievable given Australia’s current policies. Major themes that have emerged from the literature and investigations are discussed to explore these points. While parallels with prison healthcare are unavoidable, this discussion should also begin to illustrate divergences between healthcare in Australian immigration detention and prison healthcare. This will be dealt with thoroughly when considering whether equivalency is achievable given Australia’s current policies.

**Conceptual Issues**

Parallels exist between prison healthcare and Australian immigration detention when examining the conceptual issues faced in regards to equivalency. Beyond making the statement that healthcare meets this standard, precisely how healthcare compares to that found in the broader community and how it is applied and adapted in immigration detention are among key questions that remain unanswered. More importantly defining the fundamental question of what health means within immigration detention and for detainees is another issue that has been overlooked [11]. An issue that has received attention throughout the literature relates to whether health outcomes should be included when considering equivalent healthcare. Only taking into account the process of healthcare further leaves inequalities “unrecognised and unchallenged by masking discrepancies in what is an atypical and unrepresentative population” [18]. The specific literature related to health and mental health within immigration detention, along with its impact will be discussed below, however among the myriad of other concerns that are outlined in this article, health outcomes in Australian immigration detention arguably provide the most convincing argument that healthcare cannot be provided to an equivalent standard.

**Clinical, Ethical and Environmental Considerations**

**Autonomy and Self Determination**

Like healthcare in prisons, patient autonomy and self-determination are compromised. Assessments are conducted upon entry and at a number of intervals while detained [10]. Although consent is sought this process can be...
relatively imposing. Furthermore, and unlike a community setting where patients will have a choice as to whom they see and how they approach treatment, this is limited in immigration detention with detainees having to negotiate care almost exclusively with IHMS and the immigration department. More fundamentally, the detention environment changes the nature of the treatment relationship, and more generally like other detention settings, is not conducive to autonomous decision making [11].

Refugee and Asylum Seeker Health Status and Pre-migration Trauma

Refugees and asylum seekers are a particularly vulnerable and diverse population. They come from varying cultural backgrounds with many exposed to prolonged trauma before leaving their country of origin. Physical and sexual trauma is common as are other acts of violence and torture. A study conducted in the US found that asylum seekers reported numerous traumatic experiences pre-migration, with 74% describing experiences consistent with international definitions of torture. 67% had been imprisoned, 59% reported that a family member or friend had been murdered, and 26% reported having been sexually assaulted [19].

The impact of trauma is complex and varying, however plays a large part in the significantly poorer health in these populations, even before leaving their country of origin. While seeking asylum many more are exposed to further traumas, taking dangerous, often prolonged journeys to safety with no guarantees of safety or certainty [20, 21]. Regardless of migration trajectory, health status amongst refugees after resettlement is significantly poorer than that found in the wider community [22–27]. Post migration stressors also have a significant impact on health and wellbeing. Immigration detention is a particularly damaging post-migration stressor having a long term impact on mental health, becoming more damaging with time and persisting after release [28–31]. Also well documented within immigration detention are epidemic rates of self-harm [32] multiple deaths [33], violence, riots and widespread physical and sexual abuse of adults and children, particularly in offshore centres [3–5]. All of this creates a uniquely damaging environment in which health is devastatingly impacted, far removed from anything found in the Australian community.

Confidentiality

The principle of equivalence implies that those detained would have the same rights as those in the community to determine what happens to their medical information, however this has not been the case. Evidence suggests that normal standards of confidentiality have not been observed, with non-medical staff having access to medical

Secrecy, Oversight and Accountability

There has long been a culture of secrecy surrounding Australian immigration detention, something which the government has taken unprecedented measures to re-enforce and maintain. While not only attacking critics [34] and even raiding the offices of contractors in an attempt to find leaked information [35], the government has legislated secrecy with clinicians now facing 2 years in gaol for speaking about any aspect of their time in immigration detention [36]. This has come after more subtle changes that have sought to limit oversight, including the disbandment of the Immigration Health Advisory Group (IHAG), an independent group who provided oversight and advice on healthcare issues [37]. Under such conditions, it becomes extremely difficult to provide clinically and ethically sound care [38].

The government has also played an active role in preventing research in this area at times even attacking researchers. Newman, Dudley [39] discuss how the department reacted to Steel and Silove’s [40] research:

The Immigration Department attacked the credibility of professionals who publicly sought to challenge policy. It did not readily grant independent researchers access to the detained population, raising complex ethical and scientific dilemmas as to how best to proceed to investigate a vital issue. Steel and Silove argued that there remained a professional imperative to pursue the research agenda, independently of government if necessary, provided that detainees were not put at risk of harm. In practice, this meant obtaining necessary university ethics clearance for research projects rather than requesting direct permission from the Immigration Department. Yet once Steel and Silove published their research group’s findings, the Immigration Department entered into the research debate in an unprecedented way, directly criticizing and attempting to dismiss findings relating to the high rates of mental disorder amongst the detainee population. The Department went so far as to hire a private psychiatric consultant who made false accusations of scientific fraud against this group of researchers. They were also accused of letting their position as advocates bias their scientific results.

These measures are unprecedented and there are no parallels that can be drawn to the secrecy measures in Australian immigration detention and the broader Australian community or even Australian prisons.
information [41] and the immigration department interfering with clinical recommendations and advice [3]. Furthermore, leaked documents suggested that this information had even been sought for political purposes [42] with these issues appearing to be pervasive and longstanding [43].

Clinical Independence and the Use of Clinical Expertise

The immigration detention environment and related policies place multiple competing obligations on clinicians. The objectives of other parties in immigration detention diverge significantly from that of clinicians so it is not uncommon that healthcare is subverted to other objectives, with treatment advice routinely dismissed or not acted upon [44]. Often forced to compromise, pressure is also placed on clinicians to provide expertise for activities that almost solely serve the immigration departments interests. Many parallels may be found here with prison healthcare when considering assessing detainees in isolation or those on hunger strike [45], however clinicians in immigration detention may also fulfil a number of additional roles, such as also being utilised in activities such as deportations.

The Immigration Detention Environment

Like many of the other issues discussed, it is difficult to begin to find comparisons between the broader Australian community and the detention environment. As noted above Australia continues to maintain immigration detention centres on mainland Australia and on Manus Island and Nauru, while the conditions in these centres vary significantly, they have been universally criticised for being harsh, isolated and damaging to health. The impact on health and wellbeing were discussed by Coffey [46]:

The detention centre environment is particularly unconducive to a mentally ill person re-establishing his or her social identity and functioning. Generally the detention centres, however much they vary, provide socially impoverished and artificial environments with few recreational activities, and the opportunities for the development of interests, and worthwhile pursuits are limited even by the standards of many prisons. A number of detainees who had previously been imprisoned in Australia, have informed me that they found prison facilities significantly superior.

If anything, this statement shows a great deal of restraint, with a number of other authors suggesting that these environments contribute in large part to state sponsored abuse [47] and even torture [48]. These statements have particular relevance to offshore detention, where conditions have been reported as significantly worse [3, 4]. Furthermore, offshore centres appear to promote public health issues and communicable disease, for which they are largely unequipped to deal with [49].

Is Equivalency Achievable in Australian Immigration Detention?

The preceding discussion illustrates a number issues related to equivalency in Australian immigration detention. As noted above this article examines [1] whether the principle of equivalency is being applied in Australian immigration detention and [2] whether this standard of care is achievable given Australia’s current policies. Despite the ongoing claims by the immigration department and IHMS, the principle of equivalency appears to be far from being realised. Healthcare processes resemble nothing found in the broader community, confidentiality is compromised as are clinicians, the detention environment itself is damaging all while operating under a veil of secrecy. This needs to be considered against the vulnerabilities and already compromised health status of those detained, along with the persistently poor health outcomes seen in these environments.

So is this standard of care achievable given Australia’s current policies? Beyond the inadequacies related to the principle of equivalency itself [18, 50], there are a number of other considerations unique to immigration detention that suggest this standard of care is unachievable without significant reform. Although conditions within Australian immigration detention have a number of parallels to those found in prisons [3] there remains important distinctions. Those detained have not necessarily committed a crime, individuals are often held for prolonged periods with no clear timeframe for release. Perhaps where immigration detention diverges most dramatically is that the main intent of these policies is to deter further asylum seeker boat arrivals. This ends justifying the means approach is something that has been endorsed by successive governments and can be found throughout the political and popular discourse in Australia [51–54], Australian immigration detention therefore goes beyond a loss of liberty. Suffering has been built into this system. More recently this was discussed by the former Medical Director of IHMS, Dr Peter Young [41] and has lead Isaacs [48], another former employee, to question the parallels between immigration detention and torture. As well as the system acting as a deterrent, healthcare has been limited contractually to meet the immigration departments requirements, often markedly different from what may be found in the wider community. Healthcare is therefore limited and transformed by design so the idea of equivalency is compromised at the outset. As
long as Australian immigration detention remains in its present form equivalency is unlikely to be achievable or sufficient. Similar to what has already been asked in prison healthcare [11], the questions should not be whether equivalent care can be achieved but rather what can be done to mitigate the negative impact of Australian immigration detention and what can be done to better allow those detained to function in these environments. Quite obviously this remains far from ideal, so are there other options to improve health and healthcare?

Beyond Equivalency

How else may health and healthcare be improved in Australian immigration detention? While this is an area that deserves greater attention, a number of recent discussions have centred on how clinicians and the broader healthcare community should respond. Could this change come from within, by clinicians changing how they practice, or standards being raised? It is difficult to see how this would significantly shift health and healthcare as immigration detention undermines the principles that would normally drive clinical and ethical decision making. While there has been resistance from clinicians there has been little systemic change. Professional bodies have long engaged with Australian immigration detention, however have offered little more than criticisms and position statements. The government has ignored and dismissed these concerns for years. A boycott was specifically discussed recently at the Australian Medical Associations (AMA) forum on the health of asylum seekers [55], however the AMA and other professional bodies have stopped short of calling for a boycott or any collective political action. If significant change is to be realised, it will come through major reform and collective political action. A number of authors have called for this [56–58] and the case for political action was made many years earlier by McNeil [59].

The justification for engaging in these activities lies in a moral obligation to oppose inhumane treatment and a recognition that reasoned argument may be insufficient… There may well be good justification for a conservative stance, and non-response, in situations in which the wrongs are equivocal. In clear cases of humanitarian and human rights abuses that involve serious adverse affects on health and wellbeing, political action is called for from organisations that claim public health or ethics as their business.

As long as Australian immigration detention is geared to promote suffering as a means of deterrence, there looks to be few ways to address these issues in any capacity, let alone achieve health and healthcare that are equivalent to that found in the broader Australian community. Acknowledgement of the inconsistency between rhetoric and reality is required on the governments behalf, that or significant reform, where the health and wellbeing of those detained is placed first.

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VIEWPOINT

Mental health of children and adolescents in Australian alternate places of immigration detention

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Children Detained in Australian Alternate Places of Detention

Over 25 years, Australia’s policy of mandatory immigration detention has resulted in the detention of tens of thousands of adults and children, often for protracted periods of time.1 Immigration detention centres (IDCs) have been maintained on the Australian mainland and in offshore locations on Manus Island (Papua New Guinea) and Nauru. The primary objective of these policies has been to deter further asylum seeker arrivals, with this made explicit by both major political parties.2,3 The impact of these policies has been well documented with damaging and long-term impacts on mental health,4–7 epidemic rates of self-harm and suicidal behaviour8,9 and multiple deaths.10 These policies have been called ‘uniquely draconian’,11 state sponsored abuse8 and more recently lead a growing number to question the parallels between Australia’s policies and torture.12–15

A particularly concerning and controversial issue relates to the detention of children.16,17 While recent attention has understandably shifted to those held on Nauru (where 45 children remain as of October 2016),16,18–20 Australia has also held asylum seeker children in detention and community settings on the Australian mainland and Christmas Island. Until May 2016, children were detained in held detention,21 including alternate places of detention (APODs), immigration residential housing and immigration transit accommodation, as opposed to IDCs. While there are no longer any children in held detention, numbers have fluctuated over the years (e.g. in July 2013, 1992 children were detained)21 and many remain in restrictive conditions in the community. In October 2016, 251 children were held in community detention and 4021 were on Bridging Visa E, both of which have also been identified as harmful, with many aspects of life still dictated by the immigration department.22,23 While it is difficult to track, it is likely that many of those now in the community were formerly held in both offshore and onshore detention.

The remainder of this article will refer to all forms of onshore detention in which children have been detained (immigration residential housing, immigration transit accommodation and APODS) as APODs. While conditions between centres vary, they are comparably better than IDCs. The following descriptions were provided in the Australian Human Rights Commission (AHRC) Forgotten Children Report.16

The facility [Sydney Detention Centre] contains four duplex houses, each of which has three bedrooms, two bathrooms, shared kitchen, living and dining areas and a garage area that can be used for visits. The houses face a common area which contains grassy space and a small garden. There is a children’s playground, a basketball half-court and a small undercover recreation area. It is next to Villawood Detention Centre. The facilities are highly preferable to other detention facilities in Australia. However, Sydney Detention Centre is still a locked detention facility where people are not free to come and go. (p. 174)

The Inverbrackie Detention Centre in Adelaide comprises 75 houses … Unless the houses are occupied by a large family they are usually shared with other families. These houses provide a friendlier environment for children. Families have some privacy and while they may share a kitchen space, they are able to cook and eat together. Nevertheless, there are reminders that Inverbrackie and Sydney are detention centres. There are four head counts per day and people are not free to leave the fenced communities. (p. 130)

Rationale and Methodology

The conditions under which children and adults are detained in Australia are diverse, broadly labelling them as detention or otherwise fails to recognise the unique impact of these environments. With the exception of the AHRC Forgotten Children Report,16 there have been no investigations that have considered the impact of APODs in any depth. Understandably, the impact of these environments has been easy to overlook when compared to conditions on Nauru and in other IDCs.

Between 2011 and 2015 the authors worked for the detention health contractor, International Health and Medical Services in IDCs, spending majority of their time working in onshore IDCs and APODs. We felt compelled to write this paper a number of years ago, however were unable to publish it because of the introduction of the Border Force Act, legislation that made it a criminal offence for former staff to speak about any aspect of Australian immigration detention. This legislation was only recently amended, allowing some current and former staff to disclose such information.24

The aim of this article is to provide greater insight into the impact that APODs had on children and families, expanding upon...
a number of the themes raised in the AHRC Forgotten Children Report\textsuperscript{16} and drawing upon the authors’ experiences having worked as mental health clinicians in these environments. This article will provide an overview of issues that are particularly pervasive and damaging in APODs. We opted not to use case studies to achieve this as we felt that placing vulnerable children and families at further risk could not be justified in this case. Although some of the themes raised are not new in the broader literature related to Australian immigration detention, we feel APODs deserve to singled out for the harm they have caused. We also hope this article contributes to the broader discussion in relation to the detention of children with many of the issues discussed here, pertinent to other detention settings.

**The Impact of Alternate Place of Detention on Health and Health Care**

Children formerly detained in Australia’s APODs came from diverse backgrounds and had often been exposed to a range of traumatic events prior to arrival. Pre-migration trauma, cultural background, along with a multitude of other risk and protective factors contributed to significant variation in presentation, including behaviours, coping, emotional well-being and mental health. Many children were in detention for prolonged periods in their home and third countries, some were born in detention. Majority of children had suffered significant trauma in their country of origin and as a result of their journey to Australia, with some having witnessed the death of family members at sea.

After arriving in Australia, many also had varied experiences in immigration detention that further complicated their mental health and well-being after arriving in APODs. A major issue that underpinned all others related to the length of time children and families were detained, with the impact of detention becoming obvious in a number of weeks. Increasing time detained further compounds almost all issues discussed throughout this article including disempowerment and family breakdown, neglect and child protection. Health and wellbeing are further impacted by the environment, also becoming more problematic with time; activities become repetitive and monotonous and institutionalised aspects of life become increasingly tedious and frustrating.

**Facilities, activities and the detention environment**

Facilities in APODs were generally clean and functional; however, there were many reminders that they were closed, institutionalised environments. Movement was restricted, children and families were not free to leave and individuals were searched upon entry, including children coming from school. Communication with the outside world was restricted; surveillance was obvious and ever present. All aspects of everyday life were controlled by either the immigration department or security contractors, with individuals and families having to ask for permission for even the most basic day-to-day items. There were a number of activities run on a monthly or weekly schedule and limited number of excursions available; however, these activities were inadequate, particularly for those who had been in detention for prolonged periods.

There was little opportunity for children to socialise and a very limited scope to participate in activities outside of school. The environment and restrictions on visitors made it nearly impossible for children to organise activities within the detention environment, such as birthday parties; it also made it extremely difficult to participate in activities held outside the centre.

Relocations within the detention environment and between detention centres were common, with individuals including children granted little control over their accommodation and movement. This occurred within centres or between centres. Families were often given very short notice when they were required to move and little advice was provided as to why the move was necessary. This led to many seeing this as an arbitrary and punitive measure. If moving between centres, children and family were often removed from the few support networks they may have established and schools they were attending.

As a whole the detention environment, activities and associated restrictions only furthered a sense of isolation with children and families unable to establish a sense of safety and belonging. The limited opportunities for socialisation and play only further impaired development and limited children’s ability to gain commonalities with peers. This was compounded by the shame and stigma of being detained, further alienating children. Many of these themes were also discussed throughout the AHRC Forgotten Children Report.\textsuperscript{16}

**Parental disempowerment and family breakdown**

The impact that immigration detention had on the breakdown of families has been discussed elsewhere, so it is discussed only briefly here. The AHRC\textsuperscript{16} Report spoke extensively about parental disempowerment within immigration detention:

> Detention environments are designed so that adults and children passively receive services rather than manage their own environments. Adults are restricted in their ability to carry out routine parental functions and have limited decision making authority. Parents are unable to decide what health service their children receive or when. They do not make the decisions about their child’s school education. If school is not available, parents in detention are powerless to change this situation. Parents are not allowed to accompany their children to school and they cannot take their children to the local park. All decisions are made by the Department of Immigration and Border Protection or by Serco officers. (p. 128)

Often dealing with significant trauma and along with the devastating impact that immigration detention had on mental health, this lack of autonomy often became distressing for parents. Children quickly became aware of this distress which in turn created what could be best described as self-perpetuating distress and helplessness about parenting, family roles and attachment. Mares and Jureidini\textsuperscript{25} found that among 10 children interview aged 6–17 years all expressed anxiety about their parents’ well-being, this is consistent with our experiences. Furthermore, this distress and helplessness only further increased the likelihood of neglect.\textsuperscript{26}

The response to family breakdown and neglect from the immigration department and security contractors was often concerning. Failing to consider trauma, the impact of the detention environment and the compounding cycle of distress and
disempowerment, the response was often punitive with parents and children reprimanded when they were clearly not coping with their circumstances. Such a response not only failed to deal with the source of the problem, but in many ways increased the likelihood of future neglect. This punitive approach has been discussed previously as an issue more broadly throughout the immigration detention network.27

Child protection

Although child protection arrangements in onshore APODs appear to be less problematic than those on Nauru, we have frequently had to contend with a number of deficiencies largely stemming from a lack of coordination, unclear guidelines and shifting responsibilities between state and federal departments. Responses to abuse were frequently delayed or inadequate with children remaining exposed to abuse (or risk of abuse), while alternate arrangements were negotiated. Responsibilities for the management of situations were also muddied because of this.

Alarmingly and as discussed by Peter Young, the former medical director of International Health and Medical Services27 there were a number of parallels between immigration detention and environments in which child abuse has occurred in the past. APODs did little to alleviate these systemic, institutionalised concerns. There were significant power differentials, transparency and oversight were limited and the concerns of the immigration department took precedence, with the department and security contractors often having the final say in all matters related to the welfare of those detained. Deficits in child protection across the detention network, with ongoing reports of abuse, violence and neglect continue to emerge.28,29 Furthermore and in the case of unaccompanied minors, the Minister of the immigration department became their guardian once detained.18,27 So the individual ultimately responsible for their welfare was also inflicting harm. This obvious conflict remains an issue throughout the detention network.

The separation of families

The AHRC16 Forgotten Children Report discusses the separation of family members in detention, mainly in offshore centres and in regards to transfers to the mainland. The separation of families was also common in mainland detention and APODs. Most commonly, in our experience, this involved fathers removed to IDCs, while other family members remained in APODs or the community. To those detained these separations appeared to be arbitrary and politically driven. This had a devastating impact on children and families and further compounded the issues discussed above, particularly in relation to parental disempowerment and the breakdown of families. These separations occurred and were often maintained against clinical advice, with the objectives of the immigration department and security contractors overriding the best interests of children and families.

Clinical and ethical issues

The clinical and ethical issues that Australian immigration detention creates have been discussed elsewhere.30–35 APODs did little to alleviate these concerns. Broader systemic issues related to deterrence, security and secrecy were present in APODs. Health care was largely dependent on the cooperation of other stakeholders, something which was often not forthcoming. Clinical advice was frequently dismissed or ignored with it largely the immigration department’s decision whether to pursue or approve external services and treatment. We encountered countless examples of simple items or services being denied or deemed as ‘unnecessary’, including referrals for external health care services and the provision of essential items.

A further issue that deserves consideration relates to the involvement of multiple contractors and welfare agencies. In APODs, families and children were often in contact with multiple agencies dealing with a range of welfare, legal, resettlement and human rights concerns. This often resulted in a duplication of services and like health care more generally these organisations often had little power to make tangible change. For children and families this only further contributed to a sense of hopelessness, helplessness and distrust of services and raised questions about the roles and purpose of having multiple welfare agencies and whether they may be doing more harm than good.

Conclusions

APODs had a devastating impact on children’s mental health and development, particularly for those detained for prolonged periods and those who had significant prior trauma. This is consistent with the broader literature that has examined the impact of Australian immigration detention policies.4,7,27,34–36

While APODs offered a number of superficial improvements to offshore and other detention environments, mediating some harm, they quickly became damaging; APODs were far from benign and should not be considered as an alternative to immigration detention. In the longer term, these environments did little to buffer against a system which is purposely designed to inflict harm.12,13,37 A ‘kinder’ version of systematic abuse is systematic abuse no less. The children and families who were detained in APODs were among the most vulnerable; in need of the most supportive environments to overcome the adversity already faced. This can only be achieved by abandoning all forms of held detention for children and families.

For clinicians and the broader health-care community, APODs should not be overlooked in future discussions as to how we should respond to and engage with Australian immigration detention. For children and families, all detention should be opposed. A number of professional bodies have held this position for some time.38–40 Our experience further reinforces this. Although there are no children presently detained in APODs, there remains bipartisan support for increasingly harsh policies aimed at asylum seekers and refugees; clinicians and the broader health-care community should not become complacent.
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The Ethics of Discharging Asylum Seekers to Harm: A Case From Australia

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Abstract In February 2016 a twelve-month-old asylum seeker, who came to be know as Baby Asha, was transferred from Nauru and hospitalized in Brisbane. This case came to public attention after Doctors refused to discharge Asha as she would have been returned to detention on Nauru. What in other circumstances would have been considered routine clinical care, quickly turned into an act of civil disobedience. This paper will discuss the ethical aspects of this case, along with its implications for clinicians and the broader healthcare community.

Keywords Refugees ∙ Asylumseekers ∙ Ethics ∙ Discharge

Australian Immigration Detention and the Case of Asha

In June 2015 a five-month-old asylum seeker who would come to be known as “baby Asha” was transferred (along with her family) from the Australian mainland to Nauru, in what doctors warned was a “potentially catastrophic” move (Doherty 2016b). While in Nauru she suffered accidental burns and was transferred back to Australia and admitted to Lady Cilento Hospital in Brisbane. She came to public attention in February 2016, aged twelve months, when doctors refused to discharge her from hospital because they considered Nauru to be an unsafe environment. The hospital stated that, “As is the case with every child who presents at the hospital, this patient will only be discharged once a suitable home environment is identified” (Doherty 2016b). What would in other circumstances have been considered routine clinical care, quickly turned into an act of civil disobedience, creating a groundswell of support that included protests and increasing political pressure. After negotiations with the government, Asha was discharged to community detention about ten days later. Despite this compromise, the immigration minister, Peter Dutton, maintained she would eventually be returned to Nauru (Wahlquist and Murray 2016; Doherty 2016a).

Children in Australian Immigration Detention

Australia presently maintains detention centres on mainland Australia, Nauru, and Manus Island (Papua New Guinea). These policies target those who travel to Australia by boat with the government explicit that a major aim of these policies is to deter further arrivals (Kozaki 2013; Morrison 2013, 2014). In July 2013 the government announced that those who arrived by boat would not only be processed offshore but have no chance of resettlement in Australia (Rudd 2013). In October 2015, only days out from a high court hearing, the government opened the detention centre on Nauru allowing movement around the island (Allard 2017). Australia continues to pursue a resettlement deal with the United States (Daniel 2017).

While discriminating in relation to mode of arrival, Australia’s policies do not discriminate in relation to age or vulnerability. Children were detained onshore until May 2016, when all children were moved into the community (DIBP 2016). Statistics as of April 30, 2017 reveal that forty-five children remain on Nauru. Children have also been returned to onshore alternate places of detention (APODs) and community detention: fewer than five children remain detained in APODs and 216 in community detention. A further 3,818 children remain in the Australian community, on bridging visas waiting for their claims to be assessed (DIBP 2017).2

In addition to detaining children, criticism of Australian immigration detention has included breaching human rights and international law (AHRC 2014; International Detention Coalition 2011; United Nations 2017). There is robust evidence that Australian immigration detention is harmful to adults (Bull et al. 2013a; Dudley 2003; Green and Eagar 2010; Sultan and O’Sullivan 2001; Young and Gordon 2016) and children (ACHSSW 2006; Dudley et al. 2012; Isaacs 2015b; Laughland 2014; Mares and Jureidini 2004; Mares et al. 2002; Newman and Steel 2008; Steel et al. 2004; Zwi and Mares 2015). While there has been little empirical research on the long-term impact of detention on infants, the AHRC (2014, 102) Forgotten Children report concluded that there were “unacceptable risks of harm to babies in the detention environment” and that immigration detention impedes the development of pre-schoolers (aged 2–4) in a range of areas including learning, emotional development, socialization, and attachment. Immigration detention has also been found to have a detrimental impact on families and parenting (AHRC 2014; Steel et al. 2004).

Offshore processing amplifies the harms. Since its reintroduction, there have been increasing reports of physical and sexual violence, abuse, self-harm, and suicidal behaviour amongst both adults and children (Amnesty International 2016; Australian Parliamentary Select Committee 2015; Moss 2015; The Guardian Australia 2016). There have also been numerous deaths and riots (ABC News 2013; Fiske 2016). Centres are isolated, conditions are unsafe, and people suffer prolonged and damaging uncertainty about resettlement. Conditions in offshore centres have been labelled not only worse than criminal detention but as “cruel and degrading” (Mendez 2015, 7–8) and meeting accepted definitions of psychological torture (Bouchani 2016; Isaacs 2015a). Over 80 per cent of general and community paediatricians surveyed believe mandatory detention of children constitutes child abuse (Corbett et al. 2014).

The refusal to discharge “baby Asha” came at a politically charged time after the release of the AHRC (2014) Forgotten Children report into immigration detention which found that “[t]he mandatory and prolonged immigration detention of children is in clear violation of international human rights law” (29) with immigration detention having “profound negative impacts on the mental and emotional health of children” (29). Other factors included the introduction of the Australian Border Force Act in 2015, legislation that criminalized staff speaking out about the conditions in centres (Dudley 2016; Hoang 2015). Equally disturbing, the government had acted to dismiss or cover up claims of abuse and mistreatment in offshore centres (Australian Parliamentary Select Committee 2015).

Child Protection Legislation

In Australia state and territory governments legislate and administer child protection services. State-based child protection law has relevance for both suspected and actual abuse within the detention environment but has also been used to challenge immigration detention itself as abuse, however unsuccessfully.

In a similar case in 2003, paediatricians attempted to block the discharge from hospital of a six-year-old boy, calling on child protection authorities to intervene.

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2 While APODs and community placements offer a number of superficial improvements and thus remain preferable to other forms of detention, they also remain problematic. In the longer term APODs do little to mediate the harms of detention (AHRC 2014; Essex and Govinharajah 2017). Community placements raise similar concerns (Clement 2012; Essex 2013).
Intervention in this case however, was not possible as it was determined that children detained were not subject to New South Wales child protection legislation (Zwi, et al. 2003). This was also unsuccessfully attempted under South Australian law:

Although child protection is a state responsibility in Australia, the federal immigration department has responsibility for children within immigration detention centres. This was challenged by social work academics who reported suspected abuse of children in Woomera to South Australia’s child protection service in March 2002. They drew on the South Australian government’s own policy that “emotional abuse is behaviour towards a child which destroys self-esteem, confidence and a child’s sense of worth,” but the South Australian government failed to challenge the Federal Government. (ACHSSW 2006, 51)

In the case of Baby Asha the fact that legislation offered little protection did not of course absolve clinicians of their obligations; if anything it increased them. It was in this context that clinicians refused to discharge her. The remainder of this article will provide an ethical analysis of this case and explore the implications for similar future cases.

**Complex Discharges and the Case of Asha**

There is a modest literature that discusses complex discharge planning, case studies, and related ethical and clinical analysis (Banja, Eig, and Williams 2007; Moran, Gross, and Stern 2010; Schlairet 2014; Swidler, Seastrum, and Shelton 2007; Wilson et al. 2016). A complex discharge involves various contributing systemic and individual factors (Jankowski et al. 2009). However, a number of factors make the baby Asha case unique. The complex discharge literature often discusses cases where there is disagreement between the patient or a third party (or both) and the clinician. The clinicians in this case were supporting their patients’ wishes in refusing to discharge despite treatment having been completed. The third party insisting on an unsafe discharge was not a guardian or relative but the Australian government, the party who was also inflicting harm. As discussed above, there were limited legal protections in place both in Australia and Nauru at the time. Additionally, negotiations between the hospital and the government lasted about ten days, garnering significant public and political attention, turning what should have been routine clinical care into a politically charged act.

Despite these differences, the ethical basis for this action remains simple. Clinicians should not discharge people, and in particular children, to an environment in which they would be at significant risk of harm. Furthermore, clinicians have a responsibility to protect the human rights of their patients, including acting in the best interests of children. In this case, the risk of harm was well established. Nauru remains an unsafe, unpredictable, and often violent environment, that significantly impacts on adults and their ability to parent. The human rights violations are also well established.

The clinicians’ action generated relatively little controversy within the medical community. At the Australian Medical Association (AMA) forum into the health of asylum seekers, held at the time the hospital and government were negotiating the discharge, the AMA called for a “moratorium on asylum seeker children being sent back to detention centres,” along with “the immediate release of all children from both offshore and onshore detention centres into the community where they can be properly cared for” (Owler 2016). This followed earlier calls from the AMA that clinicians were ethically obliged to consider the environment to which children would be discharged (ABC News 2015) and further re-enforced by their (any many other professional bodies) long held position that children should not be detained (AMA 2011). Further justification for refusing to discharge may be found in any number of areas, including the broader complex discharge literature (Jankowski et al. 2009; Moran, Gross, and Stern 2010; Schlairet 2014).

In cases similar to Asha’s, and for particularly vulnerable patients including children, there are solid ethical grounds to refuse discharge. Thus, in similar future circumstances a strong case could be put forward for refusing to discharge if: a) the patient is unwilling to return to immigration detention, b) their return is likely to cause harm and/or violate their human rights, c) the refusal to discharge and resultant stay in hospital is not causing undue harm and, d) this refusal to discharge is not disproportionately burdening other detainees or the greater community. While most cases presenting from immigration detention are likely to meet at least some of these criteria, there are a number of other considerations.
Considerations for Future Cases

How should harm be measured? For example, on face value, a child in community detention could be considered at less risk of harm than those in offshore detention. What about the more recently enacted child protection laws on Nauru (Dean 2016); do these give some assurance as to the protection of children? If the settlement deal with the United States was transparent and timely, would this alleviate some human rights concerns? Individual vulnerabilities and circumstances will play a large role in determining how each of these is weighed. Other questions of harm relate to the disclosure of patient information. In the case from 2003 discussed above, the “treating team studiously avoided media attention, on the assumption that maintaining confidentiality and advocacy at the individual level was likely to produce the most favourable mental health outcome” (Zwi et al. 2003, 321). While Asha was a pseudonym and the publication of this case led to an eventual community placement, risks remain to the patient if any public disclosure occurs.

Another issue that relates to harm but also closely relates to justice, is the length of stay in hospital. It is not hard to imagine a similar case being played out for a month or more. The harm to the patient would not only need to be considered but the broader implications both to the general public and to others detained. It is worth addressing a potential objection to refuse to discharge here. Keeping a patient in hospital arguably incurs unnecessary expense and may potentially impair care of other children, for example by occupying a needed bed and having an effect on staffing. However these justice considerations need to be weighed against the enormous health and financial cost of immigration detention. In 2014, all major private contracts associated with immigration detention were estimated to cost over A$10 billion and healthcare alone over A$1 billion (Evershed 2014). The mean annual cost was over A$400,000 to keep each man, woman, or child on Nauru or Manus Island (Australian National Commission of Audit 2014). Cost to the community would only likely increase over time and beyond release (Bull, et al. 2013b), with a return to detention only increasing the chance of hospitalization and lifelong impairment, with significant long-term impact on society and available resources. Finally, what if the government were to stop transferring those detained offshore to Australian hospitals because of this action? This is a legitimate concern: the government has erred on transferring asylum seekers in the past, with fatal consequences (Essex 2015; Kerridge and Isaacs 2014). It would be difficult to justify such action if it disproportionately impacted the care of all other refugees in offshore detention.

While a number of positives can be drawn from the case of Asha, such as the publicity it garnered including the “Let Them Stay” campaign that arguably persuaded the government not to return over one hundred asylum seekers to offshore detention centres (Oriti 2016), there remains a number of questions. Did refusing to discharge achieve anything other than delaying the inevitable? After negotiating with the government, Asha was discharged into community detention. While this was undoubtedly better than being returned to Nauru, the government maintained that the family would be returned in the future. While this created a situation where each side could claim a victory, this only temporarily masked deeper systemic flaws (Doherty 2016c).

Finally, why have there been so few similar cases? Since the introduction of mandatory immigration detention, thousands of men, women, and children have been hospitalized, all vulnerable and all likely to be at risk of ongoing harm if returned to detention. Little will be gained speculating as to why this is the case, but turning to the future we call for collective action to empower clinicians to make such decisions in relation to discharge. Greater leadership is needed from professional bodies, hospitals, and other institutions that could provide clear guidance in future cases. The case of Baby Asha is one small victory in relation to Australian immigration detention. The impact of such action would be amplified if it were collective, something that would demand a humane response from the Australian government.

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Health, Social Movements, and Australian Immigration Detention

Australia’s policy of mandatory immigration detention has been criticized both domestically and internationally. Among these criticisms, it has been described as cruel and inhuman, and it has been likened to torture. Since its introduction in 1992, tens of thousands of adults and children have been detained in squalid conditions and for protracted (and occasionally indefinite) periods of time. Many wait years to receive any news about their refugee status.

The most controversial aspect of Australia’s policies has been the recent reintroduction of “offshore processing” on Nauru and Manus Island (Papua New Guinea). Offshore processing was introduced in 2001, repealed, and then reintroduced in 2012. Whereas all centers have witnessed sexual and physical assaults, violence, riots, self-harm, and suicide, offshore processing is uniquely damaging and has been likened to torture. Since its relaunch in 2012, conditions have become increasingly dangerous, with local communities both hostile and at times overtly violent toward refugees and asylum seekers.

CAN MORE BE DONE?

This suffering has been a direct result of Australian government policy, which has explicit political and observable political consequences. It is well recognized that the government is evasive and even combative regarding these issues; however, there remains a dissonance in precisely how these issues should be approached within the Australian healthcare community. For example, although all major professional health care bodies have opposed these policies and called for change, most of them have also supported health care as usual within the centers, thus implicitly reducing health and health care to biomedical activities and issues of justice and rights to clinical and ethical dilemmas. These policies deserve more than strongly worded statements and condemnation. The limitations of current approaches need to be more squarely acknowledged, and action must be taken beyond what is often found in the traditional repertoire of clinical and public health professionals.

PROTEST AND SOCIAL MOVEMENTS

Doctors-refugees is one such example of an organization that has taken vocal action. They have not only acted as advocates but have effectively used the media in cases of substandard care and abuse, exposing such treatment (or lack thereof) and prompting the government to act. Individual clinicians have used their experiences working within detention to bring to light the devastating consequences of these policies, even breaking the law to do so; others have called for clinicians to boycott the centers. Clinicians have also effectively acted to disrupt the system, refusing to discharge children from hospitals and return them to detention. Such actions show not only how clinicians may leverage their power by using the media, but also how they may use their positions to disrupt or resist these policies.

The health care community’s repertoire, of course, extends beyond the examples cited here. If future action is to be effective, however, there are a number of factors that need to be considered, which leads to a final important point. Among a number of other insights, the social movements literature provides a starting point to begin to consider how movements act, how they organize, and the political conditions under which they operate. It has until now been underused. Most fundamentally, this literature moves beyond blunt calls to action or identifying an obvious lack of political will; it recognizes social change as dynamic, complex, and explicitly political. Beyond Australian immigration detention, the social movements literature has broader relevance. At a time when the cooperation of government...
cannot be taken for granted and evidence and reasoned argument appear to be under increasing threat, it recognizes that health, justice, and human rights often have to be fought for.

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Should clinicians boycott Australian immigration detention?

Ryan Essex

ABSTRACT

Australian immigration detention has been called state sanctioned abuse, cruel and degrading and likened to torture. Clinicians have long worked both within the system providing healthcare and outside of it advocating for broader social and political change. It has now been over 25 years and little, if anything, has changed. The government has continued to consolidate power to enforce these policies and has continued to attempt to silence dissent. It was in this context that a boycott was raised as a possible course of action. Despite discussions among the healthcare community about the merits of such action, a number of questions have been overlooked. In this article, I will examine whether a boycott is both ethical and feasible. Taking into account the costs and benefits of current engagement and the potential impact of a boycott, more specifically the potential it has to further harm those detained, I conclude that under current circumstance a boycott cannot be justified. This however does not mean that a boycott should be dismissed completely or that the status quo should be accepted. I discuss potential ways forward for those seeking change.

AUSTRALIAN IMMIGRATION DETENTION

The introduction of mandatory immigration detention in Australia in 1992 has resulted in the prolonged and occasionally indefinite detention of tens of thousands of asylum seekers and refugees.1 2 At present, centres are maintained on the Australian mainland and offshore on Nauru and Manus Island (Papua New Guinea). While centres have now been ‘opened’ on both Manus Island and Nauru, those detained remain unable to leave and with no certainty in relation to resettlement. This has also resulted in conditions becoming increasingly unsafe and violent.3 Offshore processing was reintroduced in 2012 with the explicit purpose of detering further boat arrivals.4–8 Thus the harm created and perpetuated by these policies is both deliberate and completely avoidable. These policies have rightly been labelled ‘state-sanctioned … child abuse’,9 ‘cruel and degrading’,10 ‘a crime against humanity’11 and likened to torture.12–18

Healthcare within immigration detention centres is provided through a private provider, International Health and Medical Services (IHMS). Other external services are also often used including hospitals and allied health providers. IHMS has held the contract to deliver healthcare within immigration detention since 200719 and continues to provide services in onshore detention centres and on Nauru. IHMS only recently ceased providing services on Manus Island.

In addition to having a devastating impact on the health and well-being of those detained, Australian immigration detention also changes the nature and scope of healthcare, with its delivery described as a sisyphian task.20 The principles that underpin clinical and ethical decision-making in more orthodox settings are either absent or compromised with this transformation going beyond simply failing to meet generally accepted standards of clinical practice. A number of questions are raised as to how health and well-being should be conceptualised in these environments and if any reasonable standard of health or healthcare is achievable at all.21

Over 10 years ago, during the People’s Inquiry into Detention one mental health professional was quoted22:

You could have the Rolls Royce of mental health services in Baxter and I don’t think it would make a scrap of difference, because the environment is so toxic that you can’t treat anything meaningfully. I think that half a dozen of the most damaged people that I’ve ever seen are the adults that I’ve seen in Baxter and Woomera, both parents and single men. The thing is that it is all caused by being in detention. Provided you get them in time, you take these people out of detention and they’re not depressed anymore. Of course the interpretation of that from DIMA [the immigration department] is to say they’re putting it on: ‘Isn’t it convenient for them, the thing that was going to cure them from their depression is taking them out of detention.’ The reason it’s going to cure them is because detention is a place that drives people mad and yeah, they want to get out of the place that is driving them mad.

Outside of detention the relationship between the Australian government and the healthcare community has been antagonistic, with clinicians and professional healthcare bodies taking up a central role in a larger chorus of criticism. Human rights organisations have condemned Australia’s policies,23 former staff have spoken out, even in the face of a 2-year prison sentence under the Border Force Act.24–26 Clinicians have also protested, whistle-blown and even disrupted this system.27 Despite this, however, the government has dismissed or attempted to silence critics while continuing to pursue an increasingly punitive agenda. The legal status of Australian immigration detention as administrative detention, the bipartisan political support it has received and the governments ongoing belligerence have ensured there are few avenues for political reform or legal redress.

How should clinicians engage with Australian immigration detention? Can more be done? Should they engage with this system at all? It was in this context that a boycott was raised as a potential...
course of action. Below, I will discuss whether a boycott of Australian immigration detention is ethically desirable and feasible.

BOYCOTTING AUSTRALIAN IMMIGRATION DETENTION
A background to boycotting Australian immigration detention
Medical ethics provides scope to boycott. This is addressed by the World Medical Association:

Whenever possible, physicians should press for reforms through non-violent public demonstrations, lobbying and publicity or informational campaigns or negotiation or mediation … If involved in collective action, NMAs [National Medical Associations] should act to minimize the harm to the public and ensure that essential and emergency health services, and the continuity of care, are provided throughout a strike.

A boycott was initially raised in the literature by Sanggaran et al., who called for the discussion of ‘the potential role of a professional boycott to motivate change’. Against a backdrop of increasingly alarming reports from within detention centres and an increasingly secretive and combative approach taken by the government, including the introduction of the Border Force Act, called a boycott ‘the only ethical option available’.

The only major healthcare body to publicly discuss a boycott has been the Australian Medical Association (AMA). During its forum on the health of asylum seekers, the AMA acknowledged that Australia immigration detention amounted to a ‘state-sanctioned form of child abuse’ and called for the immediate release of all children along with a moratorium on asylum-seeker children being returned to immigration detention. The AMA also called for the re-establishment of an independent body of experts to report on the welfare of asylum seekers and refugees and furthermore, if the satisfactory healthcare could not be provided, the government’s ‘policies should be revisited’. The AMA called for no further action. The reasons against a boycott were specifically addressed. The AMA asserted that by working in immigration detention clinicians were not complicit in wrongdoing, rather they were simply placing patients first and that if any change should come, it should be through the weight of public opinion. This statement was somewhat perplexing, calling detention state-sanctioned child abuse, while also complacently calling for public opinion to first change. It also oversimplifies and denies the realities of delivering healthcare in immigration detention and is at odds with the testimony of clinicians and well-documented issues with healthcare discussed above.

Others have engaged with the issues in more depth. In an article published shortly after the AMA forum, Sanggaran, a doctor who formerly worked in detention, called for a boycott. He cites the contradictions of working within immigration detention and the AMA Code of Ethics and discusses both the compromised nature of healthcare and how clinicians have enabled human rights abuses. He also directly addresses a number of arguments against a boycott including the impact a boycott would have on those detained, that public opinion must shift first, that Australian staff will be replaced by overseas staff and the need for consensus among professionals to boycott.

A number of weeks later, Berger and Miles debated this issue. Berger, arguing for a boycott, outlined the harm that immigration detention does and the restrictions on providing healthcare in these environments, including clinicians being co-opted by the system. He went on to say that clinicians should continue to offer their services, but only if ‘the conditions for torture … end’, if clinicians have greater independence and transparency increases. Miles, who disagrees with the use of the term ‘boycott’, states that ‘these egregious circumstances do not justify a boycott that would further isolate internees from adequate care … The AMA should buttress its commendable reports and ethics codes with more aggressive action. It should help front-line clinicians to transmit reports, pictures, and data through encrypted and anonymous web channels to international human rights organisations’. Miles goes on and calls for a legal defence fund to be set up for any clinicians prosecuted under the Border Force Act and that if a boycott were to be considered, they should target the government rather than the detainees. Action could include withdrawing from working in staff clinics within government ministries (such patients can go to the regular healthcare system). It could include pausing consultative roles with government ministries, suspending the submission of government forms (birth and death certificates or medical clearance for military service), and so on.

To this point, arguments both for and against a boycott remain relatively underdeveloped. While some key questions have been asked, many points have been overlooked or deserve greater attention. Below I will expand on existing arguments while introducing a number of new points to the discussion.

A boycott, strike or something else?
As it has been discussed in relation to Australian immigration detention, a boycott has referred to the removal of all clinical staff from detention. In this respect, Miles is correct in asserting that it could also be labelled a strike. A boycott could take a number of forms; however, each changes the ethical and practical dimensions of the problem. Should a boycott involve all clinicians working within immigration detention centres? Or should emergency (or essential) staff remain? Should there be rolling boycotts? Closely related to this are the demands attached to a boycott (discussed below) along with whether a boycott should be carried out indefinitely until these demands are met. Each course of action will raise different issues, for example, if some staff were to remain, what safeguards would be put in place that protect them and the people they care for? The remainder of this article will assume that a boycott means the withdrawal of all healthcare staff from all immigration detention centres.

Beyond staffing, however, a boycott could take a number of other forms. For example, companies who profit from immigration detention could be boycotted, similar to campaigns that focus on divestment. Medical supply companies could also boycott IHMS.

Consideration also needs to be given to the conditions under which people are detained, with centres varying significantly across time and place. For example, the conditions onshore ‘alternate places of detention’ are generally preferable to those

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1 The differences and similarities between a boycott and strike will be discussed below.

2 Australia has managed immigration detention centres, immigration residential housing, immigration transit accommodation and alternate places of detention (APODs). APODs offer a number of superficial improvements compared with other forms of held detention and are often used for more vulnerable people including children and families.

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found in offshore centres. Disturbing reports from Woomera Immigration Detention Centre (open from 1999 to 2003) and Baxter Immigration Detention Centre (open from 2002 to 2007) also stand in contrast to other centres. While generalisations across centres can still be made, it is important that these differences are not overlooked if a boycott is to be justified, even in part on the conditions in which people are detained.

Key questions related to a boycott

Drawing on just war criteria, Selemogo34 highlights a number of key issues that should be considered before withdrawing services in a healthcare context. These criteria act to some degree as a safeguard, asking those who are contemplating a boycott (or strike in Selemogo’s case) to consider a series of important questions. These include (1) whether the cause for boycotting is just; (2) whether a boycott is a last resort and other non-disruptive alternatives have been considered; (3) whether the declaration of the boycott action projects the view of the majority of the peers in the profession; (4) whether in the current circumstances, the boycott is likely to achieve its objectives and finally; (5) how to ensure patients are not disproportionately harmed by the boycott action.

Would a boycott of Australian immigration detention meet any of these criteria? First, there should be little doubt that the cause of a boycott is just, for Selemogo34 this relates to intent, namely that a boycott is motivated to ‘defend (or stop grave violations of) the right to the health of individuals or communities’. For those who have called for a boycott there should be little doubt about their motivation, with little to gain personally and often exposing themselves to significant risk by calling for such action.

More doubt hangs over other questions however. Have all alternatives to a boycott been considered? As was discussed above, clinicians and professional bodies have been involved in advocacy, research, whistleblowing, protest and disruption for close to 25 years. While it seems fair to say yes, the question itself is misleading. Pursuing social change, particularly through adversarial means, often involves a broad repertoire of interrelated actions, the effectiveness of which change over time because of a number of dynamic, relational factors.35 Those seeking social change do not simply cycle through action until something is found that has an impact. Thus a boycott should not be seen as a last resort but as one option in a broader repertoire of potential action.

Selemogo’s36 third criterion relates to whether a boycott has the support of majority of the profession. Selemogo34 suggests that clinicians should have the support of a central body, whether this be a union or professional body, arguing that the support of professional bodies creates an added ‘safeguard and legitimacy’ and guards against ‘militant’ clinicians. A boycott has not yet received support from any professional bodies or agencies that represent clinicians. To this point the AMA is the only professional body to have discussed this issue and state their position publicly.2 Practically, a boycott will likely only be effective if all agree to participate. This raises the further question of whether such action should or could be enforced. If a boycott was not enforced it would risk being ineffective, as it is unlikely all clinicians would participate. If a boycott were enforced a range of further questions would be raised. Who could enforce it and how might this be done? Another possibility is that the government would employ foreign staff, which would be relatively easy to do in offshore centres. On the other hand, however, replacing Australian staff with foreign staff may also lend further support to a boycott, that is, foreign staff may provide some level of care, providing a degree of assurance that this action will not disproportionately harm those detained. A similar argument could be made if emergency staff were left in place during a boycott. These possibilities raise the issues of proportionality, something which will be discussed below.

Would a boycott achieve its objectives? Before considering whether the objectives of a boycott are likely to be met, objectives need to be set. Say, for example, that a boycott demands Australia reform its policies to be consistent with human rights and international law, should those boycotting accept compromise? What if the government offers substantial improvements to healthcare (eg, greater oversight, transparency and adequate facilities) but refuses to change other policies, such as the closure of offshore centres? While this would be progress, should it be accepted? Finally, and related to this, a boycott may not directly advance its originally planned objectives. For example, what if the greatest success of a boycott were to raise awareness and galvanise further support in the medical community.

Whether a boycott would harm those detained should weigh heavily in any decision making. Arguing for a boycott Sanggaran31 contends that “[o]ne must consider the patients’ best interests. Does it in fact serve a patient’s best interests to provide the documented substandard care? Or is the patient better served by the withdrawal of medical services so that the pretence of care is not maintained?” This is not elaborated on; however, Sanggaran31 appears to imply that no care is better than substandard care. This argument is dubious. Berger and Miles33 also fail to discuss proportionality in any depth. Other authors have turned to Lepora and Goodin’s36 framework of moral complicity to begin to analyse these issues. Weighing the costs and benefits of current engagement, while also identifying a number of ways clinicians may be able to reduce their contribution to wrongdoing while working within immigration detention, Jansen et al37 conclude that, on balance, clinicians should continue to work in detention:

Working in immigration detention centres puts doctors in an ethically tenuous position, but, on balance, it is right for doctors to continue to provide medical care to people seeking asylum. In order to do so without being unjustifiably complicit in torture, doctors must practice in an uncompromisingly humanistic way, should publicly speak out about the harms being perpetrated and should be constantly mindful of the potential for corruption.

In my previous work and applying the same framework, I came to a different conclusion, arguing that ‘current engagement with Australian immigration detention cannot be justified on balance’38 and that a ‘boycott may therefore be justified if it does not disproportionately impact those detained’.39 Below, I have changed my opinion on a boycott, so some context is needed as to how I came to the above conclusion. First, this article was written after the introduction of the Border Force Act, particularly draconian legislation which restricted what still is one of the most impactful things clinicians can do, speak of their experiences working within detention. Such action has proven powerful. With the introduction of the Border Force Act this was no longer possible. Second, I overlooked all possible scenarios that could eventuate from a boycott. As was discussed above, while we can begin to quantify the pros and cons of ongoing engagement within detention, we cannot say with any certainty what might happen after a boycott occurs. Furthermore, I failed to deal with many of the practical issues raised in this article.

Closely related to each of these final criterion is an important point which has too often been overlooked or conflated. While

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Original research

we can assess the current costs and benefits of engagement with Australian immigration detention, we can only approximate the impact of a boycott. Doubt hangs over what steps the government could take in response to such action, the compromises that might need to be made from the healthcare community, how the general public may perceive such action, and most importantly, the harm that could be done to those detained. This might already be obvious from the many rhetorical questions that remain unanswered. Future action therefore needs to consider the costs and benefits of current engagement and the potential costs and benefits of boycotting.

SHOULD CLINICIANS BOYCOTT?
A boycott is appealing when weighing the costs and benefits of current engagement. Healthcare is compromised, with interventions largely futile. Adding further weight to this is the fact the government has been unwilling to entertain alternative policy for over two decades. However when considering the potential costs and benefits of a boycott, that is, the impact a boycott could have, the same cannot be said. The potential harm of a boycott provides reason to be, at a minimum, cautious. Some assumptions can be made with more certainty than others. Swift and significant policy change is unlikely. In fact, conditions would likely worsen without the involvement of Australian clinicians. Consensus among the Australian medical community is also unlikely. Even if a significant majority of the Australian healthcare community did agree to take such action, the government would likely take steps to minimise the impact of a boycott, for example, employing clinicians from other countries to address staffing shortages. The well-documented vulnerabilities of those detained only provide further reason for caution. Taking all of this into account, a boycott becomes difficult to justify.

This is not to say a boycott should be completely discarded. A boycott may become more or less appealing depending on a number of factors. Changing circumstances within immigration detention centres would change the ethical and practical considerations in boycotting. If the government were to implement increasingly harsh measures, a boycott could be both more and less appealing. The same is true if conditions were to improve. For example while on face value it may be appealing to boycott if conditions in detention became increasingly punitive, these conditions could also leave detainees more vulnerable. Similarly, increasingly secretive policy could also make a boycott more appealing, on the other hand it may compel clinicians to stay to witness and report on subsequent abuse.

The rejection of a boycott also does not mean that we should accept the status quo. Despite 25 years demanding change from the government, there has been little critical reflection on how clinicians and the broader healthcare community should respond to these issues. There have of course been exceptions,9 which is partly why the debates in relation to a boycott were encouraging; these discussions challenged a somewhat stagnant literature and shifted focus to collective action and systemic reform. I have argued elsewhere that future research and action should focus on clinicians’ roles in social and political change, including in taking adversarial and contentious action.8 Some examples of this were already discussed above; however, there is a need for such action to be more widely embraced by the healthcare community and for greater engagement with literatures that sit outside traditional medical ethics. For example, social movement theory and theories of contentious politics34 41 provide a foundation to begin to consider clinicians as agents in social and political change. In this respect and situated among this literature, a boycott is one tool that could be used in pursuing justice for those who remain detained.

UPDATE
Since this article was written, conditions in offshore detention centres have continued to deteriorate. Disturbing reports about the mental health of children on Nauru are increasing in frequency with the situation on the island now described as a mental health crisis.52 The relationship between the healthcare community and the Australian government has also grown increasingly antagonistic. Almost every unwell child who has been transferred from Nauru has been done so by court order, despite increasingly dire and public warnings by clinicians.49 A number of doctors have been removed from Nauru48 as have the entire Médecins Sans Frontières staff on the island.45

This has been met by protest and growing outrage. Almost 6000 Australian doctors signed an open letter calling for the evacuation of all children from Nauru.46 Major professional healthcare bodies have done the same.47 Amid this pressure, the Australian government has started evacuating children who are unwell in increasing numbers.48 Public opinion also appears to be shifting, with close to 80% of Australians now supporting the resettlement of the remaining children on Nauru.49 Beyond a boycott, the voices of the healthcare community, both within Australia and globally, are needed now more than ever as there is an opportunity to capitalise on unprecedented momentum and public support.

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Psychology and Its Response to Major Human Rights Abuses

The Case of Australian Immigration Detention

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Abstract: Australian immigration detention has been criticized both domestically and internationally for the harm that it creates and promotes for violating human rights and international law. Psychologists have worked within centers and have thus been central to their operation, but have also long called for reform of these policies. Despite this and despite broader criticism from all corners of Australian society, the government has continued to consolidate power in relation to the administration of these policies and has actively attempted to shut down dissent. How should Psychologists respond? This article will argue that current approaches are inadequate and more adversarial action is needed. Supporting such an approach, social movement theory will be introduced and applied to examine how it may inform future action. Psychologists have an obligation to protect human rights and health, and while more adversarial action may not typically fit in traditional repertoires, there are few other professionals who are better skilled to begin to deal with these questions. In light of this, Psychologists in Australia and across the globe should carefully consider their roles in social change and whether they can do more in the face of major human rights abuses.

Keywords: refugees, human rights, immigration detention, social movements, psychology

Australian Immigration Detention

In 2017, 68.5 million people were forcibly displaced. Of these people, 25.4 million were refugees and 3.1 million asylum seekers (United Nations High Commissioner for Refugees [UNHCR], 2018). Those seeking safety often face numerous adverse experiences. In addition to a range of traumatic experiences in their countries of origin, dangerous journeys and protracted uncertainty in camps or third countries, there has been a growing hostility toward migration more generally, often from countries who are best positioned to help. While this has been a global phenomenon, Australia has demanded complete impenetrability of its borders for over two decades. Below I will discuss these policies, the involvement of psychologists and how I believe they should respond.

Australian immigration detention was introduced in 1992. Onshore detention centers have been maintained since this time, while offshore detention centers on Manus Island (Papua New Guinea) and Nauru were introduced in 2001, repealed and then re-introduced in 2012 (Phillips & Spinks, 2013). While anyone without a valid Australian visa can be detained for an indefinite amount of time, the most punitive elements of this policy have targeted refugees and asylum seekers and particularly those who have traveled to Australia by boat. Offshore detention was re-introduced explicitly as a deterrent to others seeking to reach Australia by boat (Abbott, 2013; Dutton, 2015; Morrison, 2014a, 2014b, 2014c; Rudd, 2013). That is, the Australian government detains men, women, and children seeking Australia’s protection in environments where violence, sexual and physical abuse, self-harm, and suicide have all been well documented as a means of deterring others traveling to Australia (Australian Parliamentary Select Committee, 2015; The Guardian Australia, 2016). The suffering produced by these policies is deliberate and completely avoidable. This has led a number of authors to draw comparisons between these policies and torture (Berger, 2016; Bouchani, 2016; Doherty & Hurst, 2015; Essex, 2016d; Isaacs, 2015a; Perera & Pugliese, 2015; Sanggaran & Zion, 2016). Others have described these policies as "state-sanctioned...child abuse" (Oliver, 2016) and "a crime against humanity" (Doherty, 2017).

Australian immigration detention has long been criticized by human rights organizations both domestically and internationally. In late 2014, the UN High Commissioner for
Human Rights raised concerns about Australia’s policies of offshore processing and boat turn-backs, noting that these were "leading to a chain of human rights violations, including arbitrary detention and possible torture following return to home countries" (Al Hussein, 2014, p. 48). Shortly after, the UN Committee against Torture released its periodic review which again cited concerns about offshore processing (United Nations Committee against Torture, 2014). In 2015, the Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment found that Australia’s policy of offshore processing had systematically violated the convention against torture, more specifically violating the "right to be free from torture or cruel, inhuman or degrading treatment" (Mendez, 2015, p. 8).

For over 25 years, the government has been belligerent and combative in the face of criticism and has continued to consolidate its power to administer these policies. Under the Australian constitution, immigration detention is considered administrative detention. That is, it is administered by the executive rather than the judiciary. Such detention is legal as long as it is not used as a form of punishment. Despite what was outlined above, the High Court of Australia has found the indefinite mandatory detention of men, women, and children to be legal and not constitute punishment (Al-Kateb v. Godwin, 2004). Since its introduction, the government has expanded its power, further shutting out the judiciary and leaving little room for legal redress. Additionally, these policies have received support from both major political parties, limiting any scope for political reform, as discussed by Grewcock (2013, p. 11):

“...both the ruling Labor party and the opposition Liberal-National party coalition share a mutual disdain for the arrival of any new boat bringing refugees into Australian waters, distinguishing themselves only by a willingness to blame the other for allowing such breaches of Australia’s forward defences or indulging in squabbles over the impact of government policy on refugee movements in the region. While this occasionally throws up superficial differences in emphasis as to how best to ‘stop the boats’, there is, fundamentally, a high level of bipartisan agreement that unauthorised refugees should be deterred through measures such as the mandatory and indefinite detention of all unauthorised non-citizens; the use of offshore processing; extensive naval interdiction programmes; and a punitive anti-people-smuggling regime.”

Despite near legal impunity and despite the power held over Australian immigration detention, the government has also sought to limit oversight and increase secrecy in relation to Australian immigration detention. The Border Force Act (2015) was passed on July 1, 2015 with bipartisan political support. For 15 months, it outlawed current and former employees speaking about any aspect of their employment in detention. Only after ongoing protest, with this legislation creating controversy where the government wanted none, was it quietly amended to allow clinicians (including psychologists) to speak out (Doherty, 2016a; Hutchens, 2017; Newhouse, 2015).

The Border Force Act was not the only means employed by the government to attack information they saw as unfavorable. Journalists have had little to no access to centers (Jabour & Hurst, 2014). The offices of contractors have been raided and their equipment seized in attempts to find journalists sources (Farrell, 2015b, 2015c). The government has also referred journalists and clinicians who have spoken about the conditions within detention centers to the Australian Federal Police (Farrell, 2015a, 2016). Attacks have extended to the Australian Human Rights Commission (AHRC). After the release of the AHRC (2014) Forgotten Children Report, which found that “[t]he mandatory and prolonged immigration detention of children is in clear violation of international human rights law” and that immigration detention had “profound negative impacts on the mental and emotional health of children” (p. 29), the government called for the resignation of the Commission’s President, Gillian Triggs (Borrello & Glenday, 2015). This disdain for human rights extends beyond Australia with the former Prime Minister Tony Abbott attempting to deflect international criticism by suggesting that “Australians are sick of being lectured to by the United Nations” (Kozali, 2015, p. 5).

Responses From Psychologists and the Australian Psychological Society

Health care is provided within Australian immigration detention centers by a private company, International Health and Medical Services (IHMS). IHMS employs a range of healthcare professionals, including Psychologists, and has held the contract to deliver health services in immigration detention since 2007. Psychologists have therefore had a central role working within immigration detention centers.

Delivering health care in Australian immigration detention has been described as a Sisyphean task (Joint Select Committee on Australia’s Immigration Detention Network, 2012). As can be imagined from the above introduction, in addition to having a devastating impact on the health and well-being of those detained Australian immigration detention also changes the nature and scope of health care. The principles that underpin clinical and ethical decision making in more orthodox settings are either absent or
compromised with this transformation going beyond simply failing to meet generally accepted standards of clinical practice (Essex, 2016a, 2016b). Psychologists (and other clinicians) have long documented the near futility of providing care in these environments. This mental health professional was quoted during the Australian Council of Heads of Schools of Social Work People’s Inquiry (ACHSSW, 2006, p. 44); little has changed since this time:

“You could have the Rolls Royce of mental health services in Baxter and I don’t think it would make a scrap of difference, because the environment is so toxic that you can’t treat anything meaningfully. I think that half a dozen of the most damaged people that I’ve ever seen are the adults that I’ve seen in Baxter and Woomera, both parents and single men. The thing is that it is all caused by being in detention. Provided you get them in time, you take these people out of detention and they’re not depressed any more. Of course the interpretation of that from DIMA is to say they’re putting it on, “Isn’t it convenient for them, the thing that was going to cure them from their depression is taking them out of detention.” The reason it’s going to cure them is because detention is a place that drives people mad and yeah, they want to get out of the place that is driving them mad.”

Psychologists have also taken action outside of detention. The inadequacy of simply working within the system has not gone unrecognized. This action has taken a range of forms but broadly has included protest, advocacy, research, and whistle-blowing (Doherty, 2016b; Tzaye, 2013). Psychologists have formed a small but important part of a larger chorus of criticism outside of detention and in calling for broader social and political change.

Along with a range of other professional healthcare bodies, the Australian Psychological Society (APS) has also called for change. The APS (2011) Position Statement on the Psychological well-being of refugees and asylum seekers in Australia, like statements from other bodies, sets out to do at least two things, makes explicit the position of the APS and provide guidance in relation to these issues. The APS calls on the Australian government to meet its human rights obligations and uphold the fundamental right of refugees to seek protection. It calls for immigration detention to be used only as a short-term option and not in offshore or remote locations. The APS opposes the detention of children. They have also notably framed their position statement more broadly than other professional bodies, avoiding the discussion of how clinicians should manage the dilemmas faced while working within immigration detention. The position statement instead raises concerns about the impact of xenophobia and racism, along with their consequences for health and well-being. The APS calls for national debates on policies such as immigration detention and for the government to refrain from actions and comments that inflame negative sentiments toward refugees and asylum seekers. They also promote Psychologies role in assisting Australian residents in adjusting and responding to refugee migration (e.g., understanding contributions refugees make, developing awareness of human rights obligations, de-bunking myths and misperceptions, and assisting them with any concerns) and promoting community-level responsibility for positive inter-ethnic relationships, understanding, collaboration, and unity.

The Need to for an Adversarial Approach

The first and most obvious reason as to why Psychology needs to reflect on its current approach to Australian immigration detention is that people remain detained, people continue to suffer, and the Australian government remains recalcitrant. Psychologists also remain central to the operation of these centers. Another reason is that Psychologists are too often involved in human rights abuses. Even recent history shows, responses from Psychologists and professional bodies have not only been inadequate, they have resulted in collusion with abuses (Boyd, 2015).

What can be learnt from Australian Psychologists engagement with these policies over the last two decades? First, little will be achieved from working within the system. This is well established. This is not to say that Psychologists should not be involved (and the debate in relation to a boycott is beyond the scope of this article; e.g., Berger & Miles, 2016; Essex, 2018; Jansen, Tin, & Isaacs, 2017; Sanggaran, 2016); however, such involvement is unlikely to lead to justice or redress for the many and ongoing rights abuses. This is why it is encouraging that the APS has framed its position statement broadly, debates are needed, racism and xenophobia are a problem, and Psychologists should have a leading role in public discourse. However, simply calling for change often does little to remedy these issues. In fact, discussion on what to do, particularly in the face of a recalcitrant government, has evolved little beyond McNeill’s (2003, p. 501) recognition of this fact over 15 years earlier:

“The acceptable public health strategies of disseminating information and advocacy may not be enough. Something more is needed. Not violence – although the Australian Government has resorted to it – for the obvious reason that in resorting to violence we become the perpetrators of harm ourselves. Reasoned advocacy may not be sufficient. It is time for a more passionate response... These actions may go beyond dissemination of information and reasoned
advocacy, and could include any number of political activities including: participating in demonstrations, direct lobbying of government members and political parties, and withdrawal of services.”

While since this time, demonstrations, sit-ins, protests, and whistle-blowing have occurred, the literature has remained relatively stagnant in its approach, largely focusing on the role of clinicians within Australian immigration detention centers. While this is of course necessary and there remains a need to support psychologists who work in these environments, this appears to have largely distracted from strategies that deal with the complexities of social and political and change. Greer et al. (2017, p. 40) discuss this frustration more generally:

“Numerous ‘calls to action’ exist in the literature, alongside calls for ‘political will’. Still more articles identify problems but offer at most policy recommendations that go unheard beyond our paywalls, as if the politicians were to blame for not reading our journals and inferring what to do. This reveals a weak understanding of politics. Public health professionals would not, for example, call for ‘individual will’ as a solution to obesity. Nor should we call for political will as a solution to policy problems.”

In moving toward a more sophisticated approach, it is useful to turn to a distinction drawn by Raphael (2009) who suggests two possible avenues for action, “professionally-oriented rational or knowledge-based approaches” and “social and political movement-based materialist or political economy-oriented approaches” (p. 145). Professionally oriented approaches entail “research, knowledge dissemination, and public policy advocacy with the aim of convincing policymakers to enact health-supporting public policy” (p. 160) and assume that governments will be receptive to ideas, whereas a movement-based approach recognizes powerful interests may be resistant to such ideas and “suggests the need for developing strong social and political movements with the aim of forcing policymakers to enact health-supporting public policy” (p. 160). Raphael (2009) argues that a movement-based approach is more effective when attempting to shift “liberal political economies” (p. 161).

Given the circumstances found in Australia, in particular the limited avenues for legal and political redress, including the governments’ recalcitrant attitude, a movement-based approach should be pursued. Psychologists (and other healthcare professionals) should re-orient their approach accordingly. Some clinicians have already taken such action. It was only recently that a boycott was debated, in large part because it appeared as though all other options had been exhausted (Berger & Miles, 2016; Essex, 2016c; Jansen et al., 2017; Sanggaran, 2016). Doctors have also been involved in civil disobedience and disruption (Essex & Isaacs, 2018; Isaacs, 2015b). While Professional bodies have typically supported such action, there has been a reluctance to fully embrace more adversarial approach with little leadership in this area (Laughland & Davey, 2014; Safi & Farrell, 2015). Often overlooked as it relates to Australian immigration detention, the social movements literature has the scope to not only better explain how Australian immigration detention is currently approached, but also assists in applying these lessons to future responses.

Protest and Social Movements

Social movements form in the face of injustice and recognize that change must be fought for. Social movements can be defined as “collective challenges, based on common purposes and social solidarities, in sustained interaction with elites, opponents, and authorities” (Tarrow, 2011, p. 9). In short, social movements are collective sustained action that attempt to bring about social, cultural, or political change (Della Porta & Diani, 2009, 2015; Martin, 2015). The relationship between human rights and social movements goes beyond simple legal aspirations, with this relationship best summarized by Nash (2015, p. 11):

“Social movements have a crucial role to play in constructing human rights if they are to be realized in practice. Rights are never effective simply because they are legal rights. Enjoying human rights in practice depends on how people use them—on what they claim, and how they make rights claims. This, in turn, depends on collective identity, on the pressure that people bring to bear because they have a “right to rights”—even where they do not have rights in law, or law is administered unjustly… Collective action is needed at every level if human rights are to make a real difference. Grassroots organizing is necessary if people are to be able to define human rights in ways that are appropriate to dealing with the injustices they face.”

The social movements literature is large and diverse, theorizing all aspects of movements including the action they employ, how the gain and galvanize support and how they respond to political threats and opportunities (Tarrow, 2011, 2013). While Australian immigration detention has galvanized a number of social movements and has been one of the most contentious political issues in Australia, the literatures on these respective topics have rarely met. Exceptions include Tszreifer (2010) who provides a descriptive account of social movements in response to the Howard
government in Australian from 1996 to 2007 and Gosden (2006) who also examines the rise of an asylum seeker and refugee advocacy movement. There is scope for greater engagement with this literature and a need to connect it to action that has already been undertaken. There are a number of reasons for this, but most importantly because it provides a foundation on which future action can be evaluated and planned.

More specifically, how could social movement theory inform a response to Australia’s policies? Social movement theory first and foremost provides a more sophisticated vocabulary to describe social and political action. It moves beyond describing a lack of political will or a simple repertoire of action, identifying important elements of movements and introducing concepts such as political opportunities, threats, and cycles of contention.

Social movement theory allows for reflection on the type of action employed and the reasons for doing so. Movements do not simply cycle through action, moving from one action to the next until something works. Civil rights were not won by simply staging boycotts. Movements employ a range of action, all of which have different impacts, but that also come with different trade-offs. Disruptive action, for example, while drawing attention to a cause, may only serve to further polarize those on either side of the debate. This is perhaps best evidenced by refugee protest within detention (Fiske, 2013, 2016). While it may garner sympathy from those who already support more humane policy, others have used refugee protest to reinforce their position that such protest is one of the reasons why detention is needed. More contained action, which is likely to attract less committed supporters, and thus, larger numbers, while less risky, may simply go unnoticed. For example, the recent Palm Sunday rallies across Australia, while large, failed to garner any significant media attention (SBS News, 2018). Beyond this, social movement theory also explores how movements organize and network, how they frame their grievances and utilize emotion to gain new supporters and galvanize existing support, and how they exploit political opportunities and respond to political threats. Below two recent examples that touch upon many of these areas are discussed through the lens of social movement theory.

Whether action is successful or not depends on a range of external factors, some more controllable than others. For example, (and as was briefly discussed above) after the AHRC Forgotten Children Report (2014) was released the government went on the attack, calling for the resignation of the then Commissioner, Gillian Triggs (Borrello & Glenday, 2015). This report, while shocking, said little that wasn’t already known about the impact that detention had on children and families. So why was there such a vitriolic reaction that inevitably increased the profile of this report? There were a number of external factors that explain this. The government at the time was defensive, attempting to justify their policies against ongoing reports of violence, assault, riots, self-harm, and suicide. The then Prime Minister was particularly sensitive to criticism, blaming the current circumstances on the previous government and even dismissing international calls for reform (Kozaki, 2015). This report came at a time when the government was actively attacking the credibility of alleged whistle-blowers and was soon to pass the Border Force Act (Doherty & Davidson, 2016; Farrell, 2015b, 2015c). The focus of this report was also a more vulnerable group (children and families) where public emotions could more easily be tapped. Thus, it was not the report itself which added anything shockingly new to the debate, but a range of external factors that led to this report gaining significant attention. Through the lens of social movement theory, the governments’ particular sensitivity to criticism could be seen as an opportunity, to further highlight the harms of these policies and generate further pressure. While protests ensued after the release of this report and children were eventually released from detention in May 2016 (Department of Immigration and Border Protection [DIBP], 2016), one can only speculate the impact of a more coordinated action.

Another important and relatively impactful campaign was the #LetThemStay campaign (Hall et al., 2018) which was launched in February 2016. National protests were staged against the transfer of 267 asylum seekers, including 54 children and 37 infants, from Australia to Manus Island (in Papua New Guinea) and Nauru. This action occurred at the same time of a High Court challenge into the legality of offshore detention and a hospitalized infant who became known as Baby Asha (Essex & Isaacs, 2018). Flown to Brisbane after being accidentally burnt, doctors at Lady Cilento Hospital in Brisbane refused to discharge her to be returned to Nauru. The media promoted this case and a protest mobilized outside of the hospital around the clock for 10 days, placing the government under increasing pressure to honor the doctors refusal to discharge (Hall et al., 2018). A number of things can be learnt from this case. Like the AHRC Report, a political opportunity was exploited. However, most importantly in this case, this opportunity was communicated to others, the media and those already sympathetic to this cause. This only further leveraged the doctors, power in refusing to discharge. What this example also shows is that without the media or the mobilization of the broader #LetThemStay campaign, the actions of these doctors may have gone unnoticed. This is a particularly important point; clinicians have often effectively leveraged their already powerful positions by engaging with the media. Doctors4Refugees are another organization who have taken similar steps. Doctors4Refugees President Barri Phatarfod provided this account:
Before moving forward, there are some potential criticisms that should be addressed. The first being that more adversarial action, to this point, has not led to change. Australia’s policies remain, rights violations are ongoing, and even in the case of Baby Asha, the family was eventually returned to Nauru (Hall et al., 2018). This is of course a reasonable position to take; however, it should also be said that other movements that have historically (and many to this day) pushed for equality and justice, such as the civil rights movement, feminist movements, the anti-apartheid struggle in South Africa, have all demonstrated that social change does happen, but often over long periods of time and in a nonlinear fashion. Social movement theory is thus not a silver bullet, it does not offer immediate solutions or a blueprint for success.

Why should Psychologists engage in such action? First there is a moral case. The harms of this system and the government’s refusal to act on evidence have already been outlined; few would deny that these circumstances are exceptional. Psychologists have also played a central role in allowing this system to function, providing health care within centers. They thus have a particular responsibility to take action, which is only amplified by the close relationship between health, human rights, and justice. There is also another good reason. There is substantial empirical evidence concerned with social change and collective action, most of which has come from psychological research. There are few other professionals who are better skilled to begin to deal with these questions.

Conclusions

Psychologists can and should engage in more adversarial action in the face of human rights abuses, particularly when those in power are unwilling to listen and other more orthodox forms of action have been exhausted. This applies not just in Australia but globally. While in this article I expressed skepticism about calls to action, this conclusion is, somewhat ironically, just that. This call to action however should only be the beginning with substantial scope...
to further our understanding of how Psychologists may contribute to social change. A more sophisticated understanding and engagement with politics is needed as is a shift in how Psychology views itself in the face of authority. Future work should also be informed by history; one does not have to look far for a repertant literature that attempts to make sense of atrocities in which psychology has played a part. And finally, for those outraged, take to the streets, consider how your skills may be used to be used in combating human rights abuses and in pursuing the greater good.

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Open letter on the border force act
Open letter regarding the **Australian Border Force Act 2015**

To: The Prime Minister, Tony Abbott,  
The Minister for Immigration and Border Protection, Peter Dutton,  
and Leader of the Opposition, Bill Shorten

Today the Australian Border Force Act comes into effect. It includes provision for a two year jail sentence for “entrusted persons” such as ourselves if we continue to speak out about the deplorable state of human rights in immigration detention without the express permission of the Minister for Immigration and Border Protection. This adds to the wall of secrecy which prevents proper public scrutiny.

**We have advocated, and will continue to advocate, for the health of those for whom we have a duty of care, despite the threats of imprisonment, because standing by and watching sub-standard and harmful care, child abuse and gross violations of human rights is not ethically justifiable.**

If we witness child abuse in Australia we are legally obliged to report it to child protection authorities. If we witness child abuse in detention centres, we can go to prison for attempting to advocate for them effectively. Internal reporting mechanisms such as they are have failed to remove children from detention; a situation that is itself recognised as a form of systematic child abuse.

Evidence of the devastating effects of institutional self-protection and blindness to child abuse has been presented before the current Royal Commission. We are determined not to collude with a system that repeats these same mistakes.

There are currently many issues which constitute a serious threat to the health of those in detention for whom we have a duty of care. The Department of Immigration and Border Protection is aware of these problems and has for years failed to address them adequately.

We are aware that in publishing this letter we may be prosecuted under the Australian Border Force Act and we challenge the Department to prosecute so that these issues may be discussed in open court and in the full view of the Australian public.
Open letter regarding the **Australian Border Force Act 2015**

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