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Proof Committee Hansard

SENATE

LEGAL AND CONSTITUTIONAL AFFAIRS LEGISLATION COMMITTEE

Migration Amendment (Health Care for Asylum Seekers) Bill 2012

(Public)

FRIDAY, 23 NOVEMBER 2012

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SENATE

LEGAL AND CONSTITUTIONAL AFFAIRS LEGISLATION COMMITTEE

Friday, 23 November 2012

Members in attendance: Senators Boyce, Cash, Crossin, Di Natale, Hanson-Young, Pratt.

Terms of Reference for the Inquiry:

To inquire into and report on:

Migration Amendment (Health Care for Asylum Seekers) Bill 2012.

WITNESSES

GORDON, Associate Professor Amanda, Honorary Fellow; Convenor, Refugee Issues and Psychology Interest Group, Australian Psychological Society

GRIDLEY, Ms Heather Margaret, Manager, Public Interest, Australian Psychological Society Ltd

NEWMAN, Professor Louise, Fellow, Royal Australian and New Zealand College of Psychiatrists

SINGLETON, Dr Gillian, Fellow, Royal Australian College of General Practitioners

YONG, Dr Choong-Siew, Psychiatry Representative, Australian Medical Association Federal Council; Deputy Chair, Australian Medical Association Public Health and Child and Youth Health Committee; Australian Medical Association Representative, Detention Health Advisory Group

ZWI, Associate Professor Karen Joy, Fellow, Royal Australasian College of Physicians

Evidence from Ms Gridley was taken via teleconference—

Committee met at 09:00

CHAIR (Senator Crossin): I declare open this public hearing of the Senate Legal and Constitutional Affairs Legislation Committee's inquiry into the Migration Amendment (Health Care for Asylum Seekers) Bill 2012. On 13 September 2012 the Senate referred the bill for inquiry and report. The committee will table its report on 7 December 2012. The bill is a private senator's bill introduced by Senator Hanson-Young and Senator Di Natale. The bill seeks to amend the Migration Act 1958 to create a panel of medical, psychological, dental and health experts to monitor, assess and report to the parliament on the health of asylum seekers who are taken to regional processing countries. The committee has received 20 submissions for this inquiry. All submissions have been published and are available on the committee's website.

I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee and such action may be treated by the Senate as contempt. It is also a contempt to give false or misleading evidence to a committee. We do prefer all evidence to be given in public but you do have the right to ask to go in camera and to have a private session. If a witness objects to answering a question, the witness should state the ground upon which the objection is taken and the committee will determine whether it will insist upon an answer, having regard to the ground which is claimed. If the committee does still insist on that answer, of course you have the right to request that that answer be given in camera. This public hearing is being televised within Australian Parliament House and is being broadcast live via the web.

I welcome representatives from the Royal Australian and New Zealand College of Psychiatrists, the Australian Psychological Society, the Royal Australasian College of Physicians and the Australian Medical Association. I also welcome Dr Gillian Singleton, who is appearing on behalf of an independent group of health experts representing key Australian mental and health professional organisations. We have received a vast array of submissions, which are on our website. For people following this, your submissions are Nos 1, 12, 13, 16 and 20. I understand Dr Singleton wishes to make a short opening statement on behalf of all of the organisations.

Dr Singleton: Good morning and thank you for this opportunity; it is certainly welcomed by the organisations we represent. As representatives of key health and mental health professional organisations we have a consensus view on the key issues relevant to this amendment and this will provide a single introductory statement, then we will welcome questions from the committee.

We largely support this amendment to the Migration Act. In the extensive experience of the group through regular visits to immigration detention centres over a six-year period, through our involvement in the former Detention Health Advisory Group, we recognise that independent oversight with review and monitoring is essential to ensure the provision of quality care which will minimise risks to clients, including depression, self-harm and suicide, and to the department of immigration. The risks of adverse outcomes would appear to be amplified for those transferred to offshore facilities as they face prolonged detention, which the evidence demonstrates is detrimental to both mental and physical health. This is in the setting of limited health services and is clearly cause for concern.

It should be noted that detention health services are provided on contract by a private organisation and thus independent review and monitoring is vital to minimise the risk of harm in challenging environments and should be established as a matter of urgency, with the aim to better identify risk factors and intervene early rather than managing the consequences of serious adverse outcomes. We believe that this expert panel should include health professionals with experience in health needs of refugees and asylum seekers, including professionals with specific expertise in psychiatry, psychology, general practice, public health, infectious diseases, paediatrics,

dentistry and nursing. Representatives with health expertise from the countries in which the centres are located should also be involved in an advisory capacity.

The concept of provision of care commensurate with that provided in the Australian community is a key feature of the health service contract with the current health service provider, and that can be easily misinterpreted. We believe that this standard should be determined by independent health experts. The organisations represented believe that the standard of care should be comparative to that provided to clients with refugee backgrounds in the community who are recognised to have particular vulnerabilities. Clients in detention often arrive with significant risk factors for physical and mental health issues which are typically exacerbated by time spent in detention. There is clear evidence that mental health deterioration is related to the length of time spent in detention. We do not believe that standard primary care is an adequate benchmark for healthcare provision in this setting.

In order to enable effective review and monitoring, the importance of access is imperative. The expert group should obviously be able to access detention centres as well as clients in detention, with their consent. Access to medical records and quality data is also important. This may require alterations to the contract with the current health service provider to ensure that they are contractually obliged to comply with any audit activities. The reporting mechanisms should not preclude regular provision of feedback to the department of immigration and preferably the immigration health advisory group which would assist in timely provision of advice, create change and mitigate risk to clients in detention and to the department of immigration.

The group should report their findings to parliament on a regular basis and have the capacity to escalate concerns to the minister and to the parliament if they are not satisfied that their concerns are being responded to and addressed by DIAC in their agreed time frames. Terms of reference for the expert panel should be determined by the group in consultation with the department of immigration. Clear time lines, work plans, feedback and compliance mechanisms should be clearly defined prior to commencement of work to minimise obstacles to efficient and effective identification of risks and the implementation strategies to minimise these risks.

The reasons for the need for independent oversight, recognised through the experience of representatives on the Detention Health Advisory Group, can be elaborated on further by individuals at the table with particular expertise, when this introductory statement is completed. We have outlined them clearly in our submission but I would just like to identify the key points now. The key areas we would like to focus on are mental health, care of minors and public health.

The key issues we have identified in terms of mental health, as I have alluded to previously, are recognising the risks of prolonged detention and adverse mental health outcomes, particularly for vulnerable individuals such as minors and people with experience of torture and trauma. The Psychological Support Program is a program which was recommended by members of the Detention Health Advisory Group aimed both at identifying and de-escalating individuals who are thought to be at risk of negative mental health outcomes. Implementation of the Psychological Support Program in remote facilities and offshore should be monitored closely. It should be identifying people in the early stages rather than waiting until there have been negative outcomes. In terms of transfers for mental health issues, we feel it is really important to clarify the criteria for removal and transfer to psychiatric facilities for those in offshore centres where local mental health services may not be highly developed or particularly skilled in managing culturally diverse individuals possibly with torture and trauma backgrounds. Critical incident response is another important area—the importance of ensuring that there are clear policies and procedures, and agreements with local health providers for responses to critical incidents, such as mass starvation and mass self-harming. These are highly specialised areas which need to be managed by health professionals with specific skills. We certainly have concerns that these skills are not readily available at some of the offshore centres.

Regarding care of minors, for child protection and guardianship laws there needs to be further clarification on what legal mechanisms are applicable to minors detained offshore to ensure their protection, including particularly guardianship. I know that Karen Zwi is happy to address this issue which needs to be clarified as a matter of urgency. On pediatric and child mental health services, the details of provision of these services offshore is not yet available and needs to be clarified. Unaccompanied minors are particularly at risk because of lack of parental support and they are particularly vulnerable in detention. Oversight of care of this vulnerable group is essential. In terms of education, children are particularly in need of intellectual activity and education, as is the case with adults. It is known to be protective for their growth and physical and mental development and therefore needs to be reviewed and monitored.

There are a few public health issues of concern. Ensuring that public health issues are defined and addressed to minimise risk to clients, staff and the public is absolutely imperative. There are particular concerns about Papua

New Guinea, as I am sure you are all aware, including multidrug resistant tuberculosis, malaria and waterborne infections such as typhoid and hepatitis A. These are a particular risk for children. Expert advice is essential, particularly regarding Manus Island, to minimise the risk to clients that are to be housed there and to avoid preventable morbidity and mortality. It should be noted that children quickly progress to severe illness or death. With some of these infections near remote centres, being transferred to a hospital facility with pediatric capability takes time, and this raises particular concerns.

Regarding screening, the provision of evidence based screening with appropriate follow-up for individuals and regular review of outcomes of screening for this population in detention is important to identify issues of public health significance and individual risk of adverse health outcomes. The Detention Health Advisory Group have made specific recommendations to the department about general and pediatric health screening which should be implemented in offshore facilities. We are not clear if that is going to happen at this point.

In closing, this group of key health organisations strongly support the need for independent expert oversight for the provision of health services in offshore detention centres to minimise the risk of harm to clients, to staff and to the department in these challenging environments. This expert panel should be established as a matter of urgency, particularly considering the announcement yesterday regarding Manus Island and increasing unrest at the Nauru facility. Thank you.

CHAIR: Thanks. Professor Newman, do you want to add to that?

Prof. Newman: Thank you; that is fine.

CHAIR: Dr Singleton, is that the opening statement for everyone here?

Dr Singleton: Yes, that is the consensus statement.

CHAIR: Are any of you members of the Detention Health Advisory Group?

Dr Singleton: We are all members, but the group is no longer functioning. We are awaiting the formation of a new group.

CHAIR: Please provide me with some background to that. When did it stop functioning?

Prof. Newman: I have chaired that group for the last several years. The group was established after inquiries into previous issues with the Department of Immigration and Citizenship on the management of detention centres. It was established as a body of independent advisers, with members nominated by the relevant professional bodies and the AMA. We have been on that committee. The aim of the committee was to provide independent advice about better management of health and mental health issues for the detention system. As part of that role there are several key achievements, but one of them has been the development of the psychological support program and other building-up of mental health expertise within the system, as we mentioned earlier. That is an issue now in terms of the new offshore centres.

The DeHAG was decommissioned in about August. Since that time we have been awaiting further developments from the department. We are told that letters have just been received by the professional bodies that a group called the Immigration Health Advisory Group will be established, again with representatives from the professional bodies. There has been an interim period where there has not been a functioning independent advisory body for the department. The mental health subgroup and the community and public health subgroups were still operating during this period.

CHAIR: Are there any health representatives on the peak immigration advisory group that is chaired by Paris Aristotle?

Prof. Newman: There is Nicholas Procter who is Chair of Mental Health Nursing from the University of South Australia. He also sits on our mental health subcommittee. He will be on the group that the minister announced the formation of yesterday as an interim joint committee with Nauru. That is being chaired by Aristotle. We would make the point that they are not representatives of any of the professional organisations and do not have that same degree of independence.

CHAIR: I want you to clearly outline, on *Hansard*, the streams where health professionals currently are in that system of providing advice. I take it then that your support for this bill locks some kind of advisory group in a legislative statute, so it is there day in and day out essentially. Is that one of the bases for your support?

Prof. Newman: Yes, one of the issues that I think is very important is that this is a standing body and it has an ongoing and very clear function. The DeHAG—and we are not sure about the IHAG, the newly established committee—have not had any clearly defined capacity to necessarily enter centres, have access to the sort of data that is very important to monitor health and mental health outcomes, nor to actually review any actions that might be taken about recommendations. I think our collective experience has been that over the years of existence of

DeHAG we have made many recommendations about things that we thought would improve health and mental health within the centres, but we have had absolutely no mandate to review the implementation of any of those recommendations. This amendment should be much clearer in terms of the power and terms of reference of a group to really oversight in a clear way what recommendations are made, what actions are then taken and whether they actually lead to improvements in the situation.

Dr Singleton: It is not clear that in the new IHAG terms of reference there will be any monitoring of offshore centres.

CHAIR: There are just a couple of things I want to ask about this legislation. This group would report to parliament twice a year but, as I read the legislation, they would provide their report to the presiding officers. I looked at that and wondered: where does the report then go? If there was such an independent health advisory body, where in the system should it sit? Should it sit under the Human Rights Commission, under the minister, under the department or should it just report to parliament? Who will take responsibility for this report? It will not be the President of the Senate, I would not have thought. Do you have a view about how the legislation should be changed or amended to better reflect the expectation of the outcomes that you have?

Prof. Newman: I think one of the key points was that, in our view, there probably needs to be another level of accountability in reporting other than purely to the department. The issue that I think we have collectively faced in terms of our work to date is that at DeHAG we have reported to the department. All our recommendations have gone to the department. It is actually very hard then to have another layer of accountability. While we welcome reporting or making the parliament obviously aware of the situation, and we believe that it is very important, we need to clarify the role of the IHAC, which is a departmental advisory committee, being established with another level of reporting and accountability.

Dr Yong: There are some analogous bodies. I previously served on the Medical Training Review Panel which reports directly to parliament and produces a report every year, but its operations are hosted by the Department of Health and Ageing. The panel probably would best fit being serviced by DIAC but clearly would have an independent report that it produces for the benefit of parliament. That way there is a different reporting line to internal departmental bodies such as the previous Detention Health Advisory Group or the new Immigration Health Advisory Group which are there to advise the secretary of the department rather than parliament itself.

CHAIR: The problem I see with this is that I see IHAG as advising on matters to do with the IHMS contract, and what might be—

Ms Gordon: DeHAG was much broader than that.

CHAIR: Much broader?

Ms Gordon: We advised on issues to do with Serco, to do with the whole operations of what went on at the centres. We would hope that IHAG would be much broader than just what is happening with IHMS. We also, through the PSP and the training that was mandated, had all the stakeholders—DIAC people, Serco and IHMS—required to have training in psychological support. DeHAG looked broadly across everything to do with health and mental health in immigration detention.

CHAIR: How do you see the body that would be established under this legislation being different to IHAG, or could it be one and the same?

Ms Gordon: I believe, if the reporting mechanisms could be properly established it could be one and the same, and then have working groups below it. I think the issue is, as Choong-Siew Yong has just said, this issue of reporting to the secretary, but also having the capacity to escalate. One of the issues with DeHAG, as Louise mentioned earlier, was that we did not always have access. For instance, the only visits that were ever made to detention centres were made when they were organised by the department. They were always prearranged, everything was very sanitised in that there were limits to what we could see and we could not see. I do not believe that if IHAG was a replica of that it would be an appropriate expert advisory oversight panel. The IHAG, if it became the expert group, would have to have proper access at its own behest. It would have to have access to records, and it would have to have proper ability to both see what is going on, to advise the secretary and then to be able to escalate if necessary to the minister through parliament.

Dr Yong: When the AMA first proposed this idea of an expert panel, the model that we had in mind was one of an inspectorate-type body which would be different from an advisory group within the department which is advising on such things as operational aspects and general issues. One of the things we are aware of is that there is currently nobody that can independently look at the situation of immigration detainees throughout the whole system, particularly now that there are offshore centres outside of Australia, and report back to the parliament or to government about the quality of the healthcare being provided, and the needs of the group. I think that you can

make a clear distinction between an internal body to the department with health expertise—which is what they have had in the past—to something that sits outside. We are certainly aware that bodies such as the ombudsman and the Human Rights Commission have not really been able to look at these issues from a detailed health perspective. They have included the health perspective to some degree. I am also aware that there are certainly issues around those bodies being able to inspect facilities outside of Australia. That may be a constitutional issue. Otherwise, the other independent groups such as the International Red Cross or Amnesty International do not have the official status that you would need for the parliament to be properly informed about what is going on.

CHAIR: Would you envisage that this group would have access to individual health records?

Prof Newman: Yes.

CHAIR: The bills digest that we have got from the library suggests that in the past there have been many recommendations made about the treatment of people who have been in detention for a long term, but those recommendations are never acted upon. One of the flaws I see in this piece of legislation is that the same thing can occur—you could make a recommendation about a particular person or a particular situation, but there does not seem to be any requirement for that to be acted on. It can just sit there on a shelf. I wonder if you have a comment about that, as well.

Ms Gordon: I think the reason we would like this group to have access to individual records is not necessarily to make recommendations on individual cases but rather to understand what are the systemic issues that arise around the health of people in immigration detention. It is less about making recommendations for the individual client, rather, how can the system change to support the clients better? That group does need to be able to make recommendations and then have a way to receive information about how those recommendations are acted upon and whether they made a difference. Part of the issue is that if an expert group makes a recommendation the only proof of whether or not it is useful is when it is implemented and we see the outcome. That also does not happen at the moment.

Dr Yong: That fits quite well within the quality processes that happen in health where, often, when the outcomes of a case have been poor or questionable, examining the progress of that case in detail can help to understand what the issues are in the system that need to be improved. It is a methodology that is very familiar to most health practitioners.

CHAIR: My last request of you is this: some of the organisations that are here today have written just one page to us saying, 'We think this is a really good idea and we support it.' All you have provided us with is a number of pages about detention and what is happening in there and the impact on people. Your conclusion is: 'so do this'. I do not really see much detail about how this legislation could be amended or approved to achieve what I think you are all after. I wonder if there is anyone in your groups who has that expertise or whether we should shoot those questions off to people like the Human Rights Commission and other groups to do that work for you. Are there elements of this piece of legislation that you think should be improved?

Ms Gordon: I think there are. Within the Australian Psychological Society—Heather, I cannot speak for the management there but I think we have some expertise that might assist in developing the policy into workable language. Would you agree, Heather?

Ms Gridley: I am sure that is true. I would first think that there are probably some legal aspects that we are not qualified to comment on. I take the senator's point that many of these submissions are quite short. But I also want to pick up what I hear from lawyers and the former DeHAG people: I feel like we are suffering a bit from submission fatigue. We have been putting submissions and recommendation in about the whole of the issues around detention and asylum seekers and mental health for probably the last 10 years. We seem to see improvements and then we see dreadful slipbacks. Whatever happens with this legislation, if it improves the power to get something implemented and not have us just feel like we make recommendations—and it depends on the politics of the day whether or not they are implemented—would be an improvement. We are probably not the ideal people to be drafting the actual legislation, but that would be the intent that I am sure we all share.

CHAIR: Thanks. Sorry, I have taken up the indulgence time of the Chair, I am afraid.

Dr Singleton: Can I make another point about that? The things that were mentioned in my introductory statement were largely around the importance of access. I do not think all aspects of that work are clarified in the bill, and that is incredibly important.

CHAIR: I assume that this body would need to be resourced and funded. I took it from your submissions that you would like the same sort of access that, for example, the Human Rights Commission gets. Is that your view?

Dr Singleton: It is.

Ms Gridley: I think it sounds like what we are saying is a combination of the access that the Human Rights Commission has and the expertise that the DeHAG people have. The Human Rights Commission does not have the health expertise but it does have a little more power.

Senator DI NATALE: Dr Choong Siew Yong made a very good point. Just to clarify the intent of the bill, this is an independent panel that sits very much outside of and separate to the work of the Departmental Health Advisory Group. That is the intent of this bill. The intent is, I take it, supported because at the moment the current process is that there is no accountability and transparency to ensure that we are getting the outcomes that we want. The bill was intended very much to serve a separate function. It was not to serve an internal departmental function but to provide an independent review by people with a broad range of expertise. I think that is how you understand that this panel will work. There are questions, I suppose, about the level of expertise within the group. I have seen submissions that argue that the expertise needs to be broader. Have you got a collective view about this sort of expertise that needs to be encapsulated through the group?

Dr Singleton: I might respond to that. As I mentioned in my introductory statement, we believe that the expert health panel should include professionals with expertise in psychiatry, psychology, general practice, public health, infectious diseases, paediatrics, nursing and dentistry.

Senator DI NATALE: And is that a collective view, supported by the group?

Dr Singleton: Yes.

Senator DI NATALE: Great. One of the questions has been about whether other groups that exist in this space have the capacity to provide that function—the ombudsman or the Human Rights Commission. Would you say that the level of expertise within either of those groups in the area of health specifically is inadequate to do what we envisage that this panel should do?

Prof. Newman: Yes. They do not have that expertise and have not worked in either a clinical or a review capacity looking specifically at health and mental health issues.

Senator DI NATALE: The other question that was raised was around the terms of reference and the specific functions of the panel. What is in the bill is quite general. Does it need to be more detailed? Should there be latitude given to the group to focus on the issues that they think are of the most importance and, by providing more specific terms of reference for the group, could we potentially limit the potential for the group to investigate areas that need attention?

Prof. Newman: I think the terms of reference need to be more detailed and more clear with respect to the function of the group, particularly on the issues, as we have stressed, of access, including access to data, and how monitoring actually works and how we operationalise that concept of monitoring and review. The DeHAG, as we said, has not previously had the capacity to be able to follow up on actions and implementation of recommendations.

I think there is expertise in the existing group and the bodies here, from our understanding of the evidence, on the risks to both health and mental health within the system, and the terms of reference should allow us to function and define those areas of highest risk. For example, we are very concerned about the length of time that people might spend within the system because length of time is clearly associated with deterioration of both health and mental health. We need to be able to look at better identification of risk factors, for example, for suicidal behaviour or self-harming behaviour. We need to be able to develop and make sure that there are proper screening and identification programs for those who are at the highest risk of developing these sorts of problems. There is an existing evidence base related to that. I think the terms of reference could be more detailed on that, but one particularly important function of this group would be better identification and monitoring of risk, and programs that the department and the system might be able to implement which will help reduce risk.

Senator DI NATALE: Do you have any specific thoughts around that monitoring function?

Prof. Newman: There needs to be a process of formal reporting and advising of recommendations that a group like this might make and then a reciprocal reporting process from the department and others—because the recommendations might also apply, obviously, to IHMS or Serco—as to what actions have been taken. That has been sadly lacking to date. And then there would need to be a review of whether the actions have been implemented and whether they are leading to change.

Senator DI NATALE: Do you see the parliamentary scrutiny of that as important?

Prof. Newman: Yes.

Senator DI NATALE: Why?

Prof. Newman: I say that on the basis—and others can speak to this—of our experience of working with the department as part of the DeHAG process. We share, I think it is reasonable to say, a common view and frustration that many of the recommendations we and our professional bodies have made have not necessarily been implemented, or there have been systemic barriers to implementation, that the reporting back to us has been inadequate, and that we are not provided with adequate data to actually make reasonable policy recommendations. So, part of the both challenge and frustration of being an independent advisory body is, of course, that you can make many recommendations and give a lot of advice that is not necessarily acted upon. So I think we would be looking at ways of actually reporting independently, if that is determined, to parliament so that there is external review and very clear review of actions according to our recommendations.

Prof. Zwi: Could I give some examples of some of the recommendations we have made, particularly in relation to child and youth health. For example, we know there is undisputed evidence about keeping children in detention and in any restrictive environment. The College of Physicians is very firm on the shortest possible time—a matter of days to weeks. That type of advice has not really been taken on board in terms of keeping children in restrictive environments in onshore processing centres, and in relation to offshore processing centres I think we gave a considerable amount of advice in terms of the risks to children—infectious diseases, overcrowding, malaria and TB. They are high-mortality environments for children. We heard that children will be transferred to Manus Island, so there are very significant concerns about independent scrutiny of the type of advice that experts around the table are giving the department.

The other things we have been talking about for many years, and have multiple times entered in submissions, is the issue of guardianship of unaccompanied minors. It is very unclear to us what will happen on offshore sites in terms of guardianship and whether it is appropriate at all for highly vulnerable unaccompanied minors without family support to be sent to such locations. We really have no response to how that will be dealt with.

Similarly, for child protection and safety issues in offshore sites, what legislation will be governing those sites. Even on the mainland it varies from state to state. There are certainly some states where child protection legislation and working with children checks are quite ambiguous. In our visits to detention centres the staff have been entirely unclear on some of those processes.

So there are significant large legislative issues that are outside of the remit of health, almost. They are whole-of-government type of issues that we really feel need high-level scrutiny to get some traction on. We have had some good responses to some smaller issues, but on some of the really big issues we really have not made any progress for a good few years.

Dr Yong: Firstly, in terms of the sort of things that have happened, one other issue I will bring up is that on occasions the department and the detention provider have come up with operational policies or plans that really would have benefited from the input around the impact on the health of the detainees. Some of the provisions that the detention provider had around managing behaviour were done without reference to the health impact.

Senator DI NATALE: Can you give me an example.

Dr Yong: The detention provider Serco has had various different methods of trying to deal with detainees who have displayed aggressive behaviour or, sometimes, repeated self-harming behaviour. One of the hard bits for us as a health group has been trying to advise on the issues around the need for security within units to keep other detainees safe, but also to bear in mind the health needs of the person, whose behaviour might be driven by a number of issues, some of which are to do with their health and some of which are to do with the environment itself. That sort of tension is something that is always an issue in any restrictive environment, so it is certainly well-known to health professionals who work in custodial settings like prisons. And it is not an easy tension to walk across.

But what was unhelpful was that many of these policies were developed without the input of the health advisory group of the department itself. The group would be told much later on, once the policy was actually operational, so the group was being reactive rather than proactive around these issues.

Senator DI NATALE: Can you be more specific about an example of the sort of policy you are talking about?

Prof. Newman: That is the Serco behaviour management policy we are referring to, which was developed between the department and Serco, and, as Dr Yong said, without reference to our group. After it was implemented we have become aware of what we would consider cases who are placed under this very strict and punitive behaviour management program, which would generally be considered on medical and psychiatric grounds to be contra-indicated. We were then shown the policy document and the way that it was implemented. We made several comments on that and commented very clearly to the department that such a program could

have very negative consequences, could actually increase risk of people's mental ill-health and breakdown, and that any decisions about the use of something like that should be made only with health advice, as opposed to the current practice, where people could be placed in these environments and decisions made by members of the department about their continuing placement in very restrictive forms of detention. I think that has been one clear issue that we have dealt with.

Another example might be our concerns about the holding of people with mental illness—as in, severe mental illness—or psychotic disorders, or other severe mental deficits, within a detention environment, and the decision-making process about at what point do people decide that detention centres are not hospitals or therapeutic environments and people actually need to go out to hospital.

So this has been a very complex decision-making process, and, largely, the health providers have felt that they too have made recommendations about people needing to be placed in a hospital or removed from centres, and sometimes that has not been acted upon.

Senator DI NATALE: To tease that out a bit: someone may be experiencing hallucinations, auditory issues, hearing or seeing things or have an acute psychotic illness and rather than being given urgent medical care the first response might be basically to confine them or handcuff them.

CHAIR: Solitary confinement.

Senator DI NATALE: Are those the sorts of things we are talking about?

Prof. Newman: Yes, on occasion. We are talking about inappropriate, restrictive detention, more restrictive detention, or what might be called solitary confinement, for people who have mental illness or, say, have mental retardation or other organic brain problems. They will have difficult behaviours to manage, which is a real problem. But placing them in restrictive detention is likely to make them worse rather than better.

Senator DI NATALE: It sounds like the 19th century sort of treatment for mental illness.

Prof. Newman: It is deeply concerning from a psychiatric point of view. It certainly is not reflective in any way of current psychiatric practice or decisions that we would make about people.

Dr Yong: Sometimes the delay has just been a delay in accessing proper assessment and treatment. So the presumption by the detention staff might be that this person is not mentally ill—that it is to do with trying to gain special privileges and so on. So the problem has been not so much just being restricted—certainly not handcuffed or anything like that—but more that they actually do not get to have a proper mental health assessment in good time.

This goes even to the planning and construction of new facilities. We certainly were aware in some of the plans around renovations to Villawood, for instance, that the department had advice from its architects around building secure facilities within the detention centre. There was a confusion by the department, and by its architects, around what the function of the secure facilities would be. So there was this idea that it could hold people who needed to be held securely because they were posing a risk to other detainees. But there were those who decided that if they are sometimes not very well, from a mental health point of view—they are sort of harming themselves—they could also be placed in these restrictive facilities rather than having to go to hospital or otherwise.

Again, there is confusion between behaviour and what might be mental illness. Our view has always been that these things need to be assessed by a clinician: someone with clinical skills in the area rather than non-clinicians working in the detention environment.

Senator DI NATALE: That issue of design is interesting. We are now constructing new facilities offshore. The thought of 10 people in a tent and a person experiencing a mental health illness in that setting rings huge alarm bells for me. We are now constructing these facilities. Has there been any advice or input in terms of the health needs of detainees during that process of construction?

Dr Yong: There has not been, no. That imposes potential liabilities on the government around inadequate consideration of the health impacts of constructing facilities, how the infrastructure of the facility is provided and so on. There may be a role for a group to provide some advice around the health impact of—

Senator DI NATALE: Are you saying that there is nothing at all?

Dr Singleton: We are disbanded. We have not been consulted.

CHAIR: I am going to interrupt here—not because this is not a very important and vital issue but because I want to draw people's attention back to the bill. It is not because I do not want to have a discussion about what is currently happening out there. Trust me, I would like to spend the day talking about it, but we have only about 15 minutes left.

There is something I asked you about that is plaguing me a little bit. There is a section in the bill that says that this committee would assess the health of an offshore entry person when they first arrive at a regional processing country. If somebody arrives by boat on Christmas Island, they get assessed. This bill would assume that, if that person is transferred to Nauru, then this advisory body would reassess that person. I took it from you that this would be a section of the legislation you think needs to be deleted or removed. I want to get this very clear from the health professionals. It is not your intention to do individual assessments and get individual records; is that correct? I want to be really clear about this.

Dr Singleton: I apologise. I intended to address that in our submission and I failed to do that. I cannot see how that would practically work. I think ensuring that the processes are in place to ensure that people are being assessed adequately is what is important.

Senator CASH: That was the point I wanted to raise as well in relation to clause 198ABA(5)(c), which does state:

assess the health of an offshore entry person when he or she first arrives in a regional processing country …

You are not going to assume the role that is currently undertaken. It is not going to be a doubling up of what is already happening, so how is that going to work in practice? Or do you say that that should be removed from the bill?

Ms Gordon: That should be removed.

Senator CASH: So that should be removed from the bill because the assessment is currently undertaken in an adequate manner.

Ms Gordon: I think that the idea was that the oversight committee would ensure that that happened.

Senator CASH: Are you saying that there are examples currently of people who come to Christmas Island for processing who are not processed in that way?

Ms Gordon: Our concern is the transfer of health records from one place to another. If people are assessed maybe when they arrive at a new place there is ignorance of the contents of the assessment.

Senator CASH: What is the current process for the transfer of those health records?

Dr Singleton: Health records are kept on a software system. When clients are transferred it is maintained in that software system and they should be able to be accessed at every site. It is a very clunky system and it does not work effectively. We have significant concerns about that.

Senator CASH: You do not actually need a new panel to determine that. The government could make changes tomorrow if they wanted to to ensure that there was access.

Dr Singleton: Yes. It is more about having review and monitoring of the process to ensure that it is robust.

Senator CASH: I want to refer to the role of DeHAG and IHAG. DeHAG was operational from 2006 until 2012. The majority of you sat on DeHAG. It is morphing into IHAG. What will be the fundamental differences between IHAG and this panel? Will they be operating concurrently?

Prof. Newman: I think the answer to that is that we are not sure—we have not seen the final terms of reference for IHAG, so we really cannot say. Clearly, what we all want to avoid is duplication, with the same people sitting on IHAG doing this work.

Senator CASH: Exactly. So, if this bill were to be passed prior to the role of IHAG actually being properly formulated, we could end up with two bodies doing the same thing—at a cost to the taxpayer.

Prof. Zwi: I think there is a clear difference, although there may be people who could sit on both. We can have a chat about it, because we haven't seen the terms of reference, as Louise said, but IHAG has been a very operational body. So if IHAG were functioning in an ideal world we would have some input into planning of services, into what the policy should be—we have all been more than willing to write policies; bring the evidence to the table; have a grown-up discussion about what would be appropriate for children in terms of where they should, maximum times and those sorts of things; mental health policies et cetera. So that would be the operational context—even discussing some of the contracts: whether the pricing of what IHMS is offering per medical consultation sounds right to us. Working in the public and private sectors, we all have some expertise in that area, so we are happy to offer that advice to the department. But our frustration has been, as we have already discussed, where that advice goes and the 'take it or leave it' approach to some of that advice. So we do feel that another layer is required, and a separate reporting process such that those operational policies, procedures and recommendations are actually enacted and monitored for things that are going wrong, which would come back in an ordered cycle.

Senator CASH: Is there any reason, though, in formulating IHAG—and you have stated that you have not yet seen the terms of reference for IHAG—that these issues could not be addressed?

Ms Gordon: There are a couple of issues. One of the things that the expert group could do would be to get information that has previously been withheld from a group like DHAG, and provide that information to the IHAG so that they could give policy advice based on that information—so, free access to records, to visit the centres in an unsanitised way to talk to client et cetera—would assist in policy development and in advice that could be given by an advisory group.

Dr Yong: What I think Professor Gordon is referring to, really, as I mentioned before, is our view that the panel should have an inspectorate type role and powers. I would argue that the timing of when this legislation goes through, as opposed to what the department might do in drawing up terms of reference for IHAG, is not a large issue. IHAG is a departmental committee set up by the secretary. The secretary will draw up his terms of reference as he sees fit. If there is existing legislation, or another body with other roles, I do not see why the secretary could not then construct the terms of reference for IHAG so that there is no duplication.

But one of the things that the internal groups cannot do is have that inspectorate type power to go and view records, view centres—even look at the contractual arrangements between the health provider and the department. That is something that is very hard for a little internal committee to have the power to do—by rights, it cannot really do that. On the other hand, a committee that is set up by parliament can have some or all of those sorts of powers.

Senator CASH: Could I just address the issue of the access to asylum seekers, because it is addressed in the department's submission. The department's submission highlights the lack of procedures in the bill to enable the panel to access asylum seekers in regional processing countries. It says:

The Bill assumes that the proposed health advisory panel will be able to carry out a number of activities in, or in relation to a regional processing country. However, the Bill does not acknowledge that this will necessarily depend on the consent and the agreement of the government of the relevant regional processing country.

Have you turned your mind to the legal consequences of that, and how a panel of this nature may be able to access asylum seekers in regional processing countries?

Prof. Newman: Clearly there needs to be, as the department quite rightly says, that agreement of the processing country to be involved in an oversight process. My understanding is that that is currently being discussed with the joint committee that has been established. It remains to be seen what conclusions come from that. But, certainly, you would have to have that capacity to visit not only the detention facilities on any overseas sites but also the health facilities there.

Senator CASH: And you would certainly envisage the panel as having those powers?

Prof. Newman: Absolutely. We do have concerns currently, particularly with respect to Nauru, about the local hospitals and their capacity to deal with some of the issues that they are already having to deal with. The hospital is run by Nauru; it is not staffed by Australian medical staff—in fact, it is staffed by medical and nursing staff who would not be registrable in Australia, so there are quality issues there. But, obviously, to inspect those facilities there would need to be fairly high-level agreement that that is acceptable.

Senator CASH: Has anybody here, given you are experts in this area, turned their mind to the potential costings involved in setting up an independent panel?

Ms Gordon: I think we have turned our minds to the costs that have been incurred so far by there not being expert advice available to the government. We are really aware that there have been vast expenses incurred because of people being ill, because of the system not working to support them appropriately—which could be cheaper than the systems that are currently there.

Senator CASH: But that is because, you say, the government has not responded to the recommendations that you have provided to date?

Ms Gordon: There are many recommendations that we have provided that would provide cost savings to the government—

Senator CASH: And the government just has not implemented them.

Ms Gordon: That is right.

Senator CASH: Could I ask you, on that point, Associate Professor Gordon: are you able to provide the committee with a list of the recommendations that you have provided to government and those which you say the government has to date not implemented?

Ms Gordon: The DHAG secretariat should be keeping a running—we have asked them to do this—list of recommendations and the outcomes of those recommendations, so that secretariat should be able to provide that information.

Senator CASH: Are we able to obtain that, Chair, through DIAC?

CHAIR: I think so. But, if you have a look at the *Bills Digest* that the library has produced, those recommendations go back prior to 2007 as well.

Senator CASH: Yes, I understand that.

CHAIR: We are talking about both governments here, to be honest.

Ms Gordon: Yes, we were established in 2006.

Senator CASH: You were established in 2006?

Ms Gordon: Yes.

CHAIR: I was referring to that before: if you just report to parliament, it seems like recommendations just sit there—this is under both the previous government and, I assume, the current government as well.

Dr Singleton: We do have an appendix to our submission, that was a consensus submission, relating to the recommendations that have been made and the achievements of the group so far.

Senator CASH: Thank you.

Senator BOYCE: I have a couple of questions in the disability area. It has been put to me by one organisation that this bill really sets out a medical model for health and mental health, particularly in terms of the fact that it just does not mention disability, and that it needs to be adapted to a social model. Could you tell me what you believe to be the gaps in this bill in terms of asylum seekers with a physical or intellectual disability.

Ms Gordon: I believe that, although it will be medical or health experts on the panel, we do not necessarily subscribe to a 'medical model' in terms of what should be supported within these detention centres. In fact, many of the recommendations we have made have been to look at things outside the normal medical model, to look at social supports, at going out to the asylum-seeker community within the detention centres instead of inviting them to come into the medical centre. So there have been many recommendations over time to move away from the medical model. I do not believe an expert advisory panel comprised of health experts is going to necessarily recommend anything to do with a medical model, but what we will be able to see are the health impacts generally, across the whole community, because of the medical expertise that we bring.

Senator BOYCE: If this bill were to proceed, you do not think the panel would need to have a person representing the disability community, or people with co-morbidities, on it?

Ms Gordon: I believe the expertise is there within the College of General Practitioners, the College of Psychiatry, the Australian Psychological Society and the AMA to meet that requirement. But, if it was felt that that would be a relevant inclusion, I don't think there would be any objection to it.

Senator BOYCE: Just so I can get a handle on what is happening now: what tools are available for communication in foreign languages for people with disability—for example, an intellectual disability or hearing problems? What do you currently use?

Ms Gordon: They have interpreters. They are not necessarily skilled beyond other interpreters, as I understand it.

Senator BOYCE: So pictograms and things like that are used?

Dr Yong: I do not think there have been specific tools available within the detention centres, but I think the health provider, IHMS, probably would provide them if their staff said there was a specific need. There is probably the issue of whether there is a pool of resources available for people with disabilities who might arrive at some of those detention centres. I think that probably is an issue, and that is one that could easily be addressed by the department in its negotiations with IHMS.

Prof. Zwi: I think there is an issue with disability, certainly with disabled children. There are not very many within the detention network, but those that are there have certainly not been treated commensurate with Australian standards. I think that is fair to say. They have been in inappropriate environments for their disabilities.

Senator BOYCE: Inappropriate in what way?

Prof. Zwi: If they are in a wheelchair, for example. When we were visiting Christmas Island there was a child who was severely disabled and was in a wheelchair. Access is very difficult in that environment. I would say they did not have access to appropriate physical and occupational therapy and other disability provisions. They had

come with a diagnosis which proved in the long run to be incorrect because they did not have specialist assessment on the island. They waited not for an extraordinary length of time but for several weeks before they had the appropriate diagnosis, and during that time the child was placed on a very restrictive diet, which was completely unnecessary, in retrospect. It is not an issue that we have specifically raised—I am a paediatrician and we have mental health experts—but we certainly raised these issues in a generic sense and we are very aware of them. If the recommendation was that an additional person addressing disability were to be on the panel, none of us would have any objections.

Senator BOYCE: I will be asking the same questions of the department later today, I have to say.

Prof. Zwi: Just on that issue, we have worked quite hard to prevent further disability, because that is the key issue. So many children and unaccompanied minors arrive without disability but we produce disability in the sense of emotional and mental health damage through some of the environments that people are exposed to or the lack of support when needed. We have made very strong recommendations around meaningful activity, children going to school, younger children going to playgroup and preschool, which is highly protective of their future development, physical and mental health. Even though some of those policies have been accepted as policy within the department, it has been very difficult to implement them in the detention network. We feel very strongly that an expert advisory committee needs to make sure those kinds of recommendations go wherever else we send children.

CHAIR: We have come to the end of our time. Ms Gridley, I know it is very difficult when you are on the end of the telephone and I am wondering if you had any comments you wanted to make.

Ms Gridley: Just two brief comments, picking up some of the things that were raised. One was in reference to the social model of health. I think if we were really applying the social model of health then people would not be there because the model is all about focusing on the conditions that promote health. Clearly, it is next to nigh impossible to actually promote health in an environment like that. The best you can do is damage control and provide reactive services, which is what people are doing their best to do.

The other thing I particularly want to mention, and I am not sure if I can ask a question, is that I did hear that there was a suggestion that detainees, particularly on Manus Island, would have access to telephone counselling services. If that is correct it is a very good illustration of a lack of advice, I would think, from experts because you cannot imagine that somebody who speaks very little English, has come in a frightened situation and is used to mistrusting authorities is going to be able to have any meaningful counselling by phone at all. I just find that quite shocking, if that is the case.

CHAIR: Thank you, Ms Gridley. Thank you all very much. We certainly appreciate your submissions and your expertise.

KARAPANAGIOTIDIS, Mr Kon, OAM, Chief Executive Officer, Asylum Seeker Resource Centre

LIONS, Ms Tamara, Government Relations Adviser, Amnesty International Australia

SCOTT, Ms Ellisa, Case Worker, Hotham Mission Asylum Seeker Project

[10:06]

Evidence from Mr Karapanagiotidis was taken via teleconference—

CHAIR: I will start by welcoming you, Kon. I am going to ask you to introduce yourself to me before I attempt your surname.

Mr Karapanagiotidis: Sure. I am a lawyer and social worker and I am the CEO and founder of the Asylum Seeker Resource Centre.

CHAIR: That is based down in east Melbourne, isn't it?

Mr Karapanagiotidis: In west Melbourne. We have been going for 12 years now, almost.

CHAIR: I now welcome representatives from the Asylum Seeker Resource Centre, the Hotham Mission Asylum Seeker Project and Amnesty International. We have submissions from your three organisations. They are numbered on our website submissions 2, 8 and 10. Do each of you have some opening comments? Let's start with Amnesty International.

Ms Lions: May I begin by acknowledging that this place where we meet was, is and always will be Aboriginal land. I would also like to thank the committee for the opportunity to represent Amnesty's views on the proposed bill today. It should be noted at the outset that Amnesty has consistently opposed the policy of mandatory detention of asylum seekers and refugees, as well as offshore processing, particularly in third country locations. Amnesty considers these policies breach Australia's obligations to provide protection to asylum seekers under the refugee convention, discriminate against asylum seekers based on their mode of arrival, are unnecessary given the comparatively small numbers of asylum seekers Australia receives, are expensive compared to other alternatives and are inhumane due to the indefinite nature of detention in remote locations.

While Amnesty does not support offshore processing, we of course acknowledge that it is the current government's preferred strategy for managing asylum seekers who arrive in Australia by boat. Amnesty therefore wishes to provide urgent feedback to government in the hope of making the operational realities of this arrangement as humane as possible.

This week my colleagues Dr Graham Thom and Ms Alex Pagliaro visited Nauru to observe conditions for asylum seekers and refugees transferred there from Australia. I would like to relay some of their findings from their visit that are particularly relevant to the bill being considered. Firstly, it is clear that poor living conditions on Nauru are already causing detainees to suffer health and mental problems. Substandard conditions on Nauru are causing stress and tension among detainees. Asylum seekers and refugees on Nauru are currently accommodated in crowded tents that are ill-suited to the hot damp climate. My colleagues observed up to 14 people to one tent. It rains often, the tents leak and all their bedding gets wet. Asylum seekers reported developing skin rashes from the damp conditions. During the daytime it is too hot to be inside the tents and there are virtually no shaded areas for asylum seekers to shelter under. People have difficulty sleeping because it is so hot. There are not enough toilets and showers for the number of people there. Detainees are not allowed to leave the camp and have very few meaningful activities to occupy themselves with. Amnesty International is concerned about hygiene problems and the potential for disease outbreak if conditions are not improved immediately.

Secondly, it is important to note the detrimental effects of long-term indefinite detention on the mental health of detainees. The claims of detainees have not yet begun to be processed and they have received no information about when this will occur or how long they can expect to be detained under the no advantage principle. This uncertainty and stress causes mental anguish for detainees who are already exhibiting signs of mental health problems. Detainees showed my colleagues scars from where they had cut themselves and a pole from which one asylum seeker had tried to hang himself. It is deeply disturbing that such behaviours have already manifested among detainees sent to Nauru. It is clear that long-term indefinite detention leads to mental health problems for detainees.

In the absence of legislative protections for refugees sent to offshore locations, and in light of observations from Amnesty's recent visit to Nauru, there is a critical need for independent oversight of the health and wellbeing of asylum seekers and refugees detained in offshore detention centres. The expert medical panel should include multidisciplinary health professionals including mental health experts. The panel should be given unfettered access to all detainees and should report regularly to the parliament and publicly.

Amnesty International supports the Australian Human Rights Commission's recommendation that the bill be amended to expand the mandate of the panel to include asylum seekers and refugees in Australia in all forms of immigration detention including community detention, particularly in light of the government's announcement this week of the application of the no advantage principle to asylum seekers processed onshore in Australia including those on bridging visas. Amnesty has regularly visited detention centres in Australia and holds similar concerns for the health and wellbeing of detainees who have also exhibited signs of poor health. It is critical that an independent panel of medical experts be established as soon as possible to help ensure better outcomes and care for asylum seekers. Amnesty International urges all parties to implement the bill as a matter of urgency.

Ms Scott: I am a caseworker currently working with Hotham Mission Asylum Seeker Project in Melbourne, which I will refer to as HMASP. HMASP works with people seeking asylum who are lawfully awaiting an outcome on their refugee or humanitarian protection claim but who face homelessness and destitution without community support. Many of our clients have suffered physical or emotional trauma, isolation and mental illness. HMASP has traditionally worked with people residing in their community, however in recent years it has commenced working in the community detention field, keeping in line with our mission to support and promote alternatives to mandatory detention.

HMASP supports the migration amendment healthcare for asylum seekers bill. It also puts forward the following recommendations in relation to the bill: that the panel include a representative from the human rights profession, that the panel be adequately resourced to perform its duties, that the panel be independent of government, that assessment and subsequent reporting of the panel take into account input from the relevant casework organisation, and that assessment and subsequent reporting be measured against standards relevant to the particular population and nature of closed environments. Considering HMASP has already elaborated on the bill in question in our submission, I think it is more pertinent to use this time to speak to you from experience. My personal employment history includes work at an immigration detention facility in Melbourne, community detention for unaccompanied minors and a brief stint in the community assistance support program for both IMA and community bridging visa clients. My current position is in the community team at HMASP. I must state that I am not representing the views of the organisations that I have previously worked with today. That said, these experiences mean I am well placed to provide a firsthand case work perspective of health conditions and ongoing effects on health of those held in closed environments.

My more recent experiences have highlighted the difference between asylum seekers who have spent time in closed environments versus those who reside in the community. Both my colleagues at HMASP and I have noted the higher prevalence of mental health issues amongst those who have been held in closed environments. These include institutionalisation, depression, retraumatisation, anxiety, distrust, suicidal ideation, attempted suicide and self-harm, to name just a few. These mental health issues and attributes then have a direct impact upon an individual's ability to be independent, to find and secure employment, to engage in meaningful activity and to become an active member of society. There is a marked difference in the ability to adopt coping mechanisms for those residing in the community. It is therefore paramount that this bill be passed to help minimise the health impact of close environments.

Whilst working at the immigration detention facility, I observed the effects that human rights restrictions have on an individual's physical and mental health. For example, it was highly common for individuals, especially those experiencing mental health issues, to struggle to attend during the strict meal times. Typically, this was due to lethargy, lack of motivation and feelings of helplessness associated with depression. Restricted access to food is a human rights issue that directly impacts on an individual's health, both physical and mental. Another example of human rights restrictions relates to the visitors policy of the closed environment that I worked in. Whilst working at the facility, I was informed by a 16-year-old boy that his sister had been denied a visitor pass to the centre. This was due to the fact that she wished to bring her two children with her to meet their uncle for the first time. The young boy was extremely distressed and disappointed, and he expressed feelings of shame and degradation. After two days of both written and verbal advocacy with centre management, I was able to organise a short visit in the restricted area so that the boy could meet his niece and nephew.

It is clear that closed environments inherently impose human rights restrictions on those residing in them and that these restrictions may have adverse psychological and physical health effects. It is therefore important that the panel include a member from the human rights profession. There are many factors that contribute to individuals not accessing health services within closed environments. Reporting on data collected solely by health providers regarding service delivery and access may result in an incomplete analysis of health provision. For example, there was one occasion where I noticed a 17-year-old boy limping through the centre at which I worked. When I stopped to ask him what was wrong, he showed me a cut on his foot that had become extremely infected.

The boy also told me that he had begun feeling dizzy and ill, and I noted that his foot was extremely swollen and red. He informed me that he had arrived late to his appointment with the doctor and had therefore been turned away. Luckily, the young boy was able to see the doctor that afternoon, following some strong advocacy from me, which was pretty much just me standing there until they would see him. Had I not interfered, the young boy would not have seen the doctor and the lack of access would not have been reported. This is just one example of a situation where health concerns are reported directly to a case worker and which provides support for our suggestion that evaluation of health services should include input from those outside the health profession.

HMASP recommends that physical and mental health services be assessed against a standard relevant to the client group and setting in which they are provided. A barrier to access of mental health services in closed environments is the inflexible nature of these services. For instance, many individuals that I came in contact with during my time at the immigration detention facility disclosed that they were uncomfortable attending appointments with mental health professionals due to cultural expectations, feelings of distrust and the rigid appointment structure. At the immigration detention facility, one of the psychologists would roam the grounds on a daily basis to make sure he was more accessible to those in need of mental health assistance. This method proved to be extremely effective. However, it is not typical practice. Considering the population is likely to have a proportion of individuals requiring physical and mental health assistance, and factors such as cultural and linguistic diversity will be at play, it is important that the panel measure the provision of health services against relevant standards. In summary, HMASP supports this bill and notes that there are factors which must be considered in order for the bill to achieve its aims. In light of recent reports of conditions in offshore processing centres it is vital that the panel be implemented with haste.

Mr Karapanagiotidis: A starting point for the Asylum Seeker Resource Centre would be that we are speaking from almost 12 years of experience, having worked with over 8000 asylum seekers—both in the community and in detention—and that we established the first health service for asylum seekers in Victoria, and the largest one in the country. The ASRC sees first-hand the damage of detention. Without doubt, we support the establishment of this panel, but we argue that the foundation starting point should be the acceptance that mandatory detention fundamentally makes people mentally ill. At its heart, mandatory detention causes trauma, post-traumatic stress disorder and damages people. We are seeing right now the most suicidal, high-risk, complex-need client group we have seen in 12 years, and the reason is that the majority of those people are people coming out of long-term detention.

For me, the issue is this; we can have all standards we want, and we can have all the policies that we want, but what I have witnessed thousands of times over in my time going into detention centres is that, at the heart of it, is a culture of neglect. A culture where the wellbeing and health of asylum seekers are never paramount. A culture where it often takes what we call three strikes and you are out, which is when you have tried killing yourself three times, you might be considered for release. What we are drastically missing is accountability. We have to remember that a system of mandatory detention exists for one purpose only and that is to deter and punish people. That is irreconcilable with mental health and wellbeing of people. We can talk about the government saying things will be different this time on Nauru and Manus Island, yet if you sat there you can see the same recipe for disaster—under-resourced mental health professionals—one part-time psychiatrist for Manus Island and Nauru—people left in limbo; indefinite detention; no legal process and no access to legal advice; no access to lawyers. This is one of those rare times where you can sit there and say a government knows something is about to be a humanitarian disaster, yet it continues unabated on and forward.

We need to ask ourselves: if we are going to have a panel like this, what does it critically need? One, it needs the power to be able to identify and anticipate the risks that we already know are there. What do the evidence and data tell us? They tells us detention harms people; in particular, unaccompanied children, women, families and pretty much everyone. In knowing that, what do we do when people begin self-harming and deteriorate. We know after six months of detention, people start to drastically deteriorate. We know that there are over 1,000 people in detention for more than two years in this country. We need a panel that has the ability to identify and anticipate risks, and once you have identified people who are high risk and people who cannot be cared for in a detention environment—which is in reality no-one—if we are going to start with at least preventing further self-harm, suicide attempts and deaths in detention—to continue our shameful history—we need a panel that has the ability to have recommendations that are in fact enforceable.

We need recommendations that are at the heart of things that hold our government responsible with everything from a legislative requirement when it comes to children; to our international treaty obligations; to the ability to have a panel that is made up of psychiatrists, human rights professionals, psychologists and people whose medical evidence is not just put forward as a recommendation, but actually has the power to trigger the release of people

who are high risk. Our big problem here is one of going: we know what detention continues to do to people. The problem is when people start self-harming and start hurting themselves, in reality, this falls on deaf ears, and they never get expedient care, quality of care, holistic care, or appropriate care.

The care that they get never results in an automatic trigger for that person to be released, because people come out and, if you adhere to the no-advantage policy—which is the idea of releasing people indefinitely into the community for five to 10 years without the right to work, or keeping people indefinitely in detention without a visa or processing—we know what is about to happen. In the next two to three years, I can say with certainty there will be dozens of deaths in detention. I can say with certainty that there will be thousands and thousands of suicide and self-harm cases. We have to sit and ask: what can a panel do and bring to the table that will be useful? That has to be about accountability, and that accountability needs to be legislated. All those detention values are bullshit; they do not mean anything in reality. Show me a single one of the current Labor government detention values that is actually being followed. We need some legislation. We need statutory obligations on the part of the government when these recommendations are put forward. We need the government to be bound to provide a mandated written response within 45 days of this report being tabled by the panel. We need to ensure we have a panel that has clout, standing, rights and, most critically independence—so it can call it like it is, hold the government to account and have binding recommendations, genuine oversight and resourcing, unlike what we have now with the Human Rights Commission, that enables it to be effective on the ground observing and holding people accountable.

CHAIR: I am going to have to stop you there.

Mr Karapanagiotidis: I think the critical thing is the importance of genuine oversight and accountability and the resourcing to ensure that happens.

CHAIR: We understand your passion but I also need to remind you that this is a session of the parliament. We will go to questions now.

Senator CASH: Thank you for your submissions. The department's submission highlights the lack of procedures in the bill to enable the panel to access asylum seekers in regional processing countries. It says:

The bill assumes that the proposed health advisory panel will be able to carry out a number of activities in or in relation to a regional processing country. However, the bill does not acknowledge that this will necessarily depend on the consent and agreement of the government of the relevant regional processing country.

Have you turned your minds to whether the panel should be allowed to have access to asylum seekers in regional countries and, if so, how that would occur?

Mr Karapanagiotidis: It is critical that you have access to those offshore locations. There is no reason there could not be a task force go there to do reviews and assessments. Given that we have responsibility and we are managing those centres, I think it is the most vital thing; they are the most vulnerable of all groups.

Senator CASH: The department states that access will necessarily depend on the consent of the agreement of the government of the relevant regional processing country. How do you think that is going to occur?

Mr Karapanagiotidis: The sovereignty argument is a furphy. Look at how things were done at Manus Island yesterday without the actual consent of the landowners there. It is a furphy. The government has the ability to negotiate that access and make it like the contractual agreements it has with anyone else. It is just a cop out. I do not believe that is a hindrance or barrier to having access. It is simply what the government hides behind. If you look at everything else they have negotiated, that overrides sovereignty. Most of the things in place on Nauru and Manus Island are against the wishes of those countries.

Senator CASH: I think you would agree, though, that, in the absence of the consent of the country in which the regional processing centre is located, it may be difficult for members of the panel to obtain access.

Mr Karapanagiotidis: But G4S contractors and the Salvation Army have access to Manus Island. The government is able to facilitate access by so many other contractors and providers. There is no reason why the government, if it believes it has a good faith commitment to this, could not broker this arrangement.

Senator CASH: Are you concerned that there is any duplication between the panel's perceived role in the monitoring and assessing of the health of asylum seekers and the role currently held by, say, IHMS?

Mr Karapanagiotidis: I think the role of IHMS is very different. While there is no genuine accountability in the oversight of IHMS, what people critically need is an independent advocacy body. By that I simply mean a body that ensures the standards, policies and legislative obligations of our government are being met. IHMS is not going to fill that role—far from it.

Ms Lions: Senator, on your first question, I also echo those sentiments. It is critical that the panel have access to the asylum seekers. I do not foresee any problems for the government in negotiating that access with the governments of Nauru and Papua New Guinea. What was the second part of your question?

Senator CASH: Do you see any overlap between the role of the panel and the current role of IHMS?

Ms Lions: I do not. The main focus of the panel should be in its reporting mechanisms to the parliament and publicly.

Ms Scott: And in the assessment of the service. The provider is doing its own assessment. I cannot think of any other system that does that very effectively in terms of any sort of assessment across the board.

Senator CASH: I do not know if you were here for the questions for the previous witness, but one of the questions put to them was in relation to clause 5C of the proposed bill, which states:

In performing its monitoring and assessment functions, the panel may assess the health of an offshore entry person when he or she first arrives in a regional processing country.

Do you see that as a duplication? The health of asylum seekers is already assessed when they come to Christmas Island. Do you see this being done a second time?

Ms Scott: I would think that the panel would have access to the initial assessment and then—

Senator CASH: So it is the transfer and accessibility to records that needs to be enabled, not another assessment being undertaken?

Ms Scott: I would think so. It would not seem practical for the panel to conduct the assessment. But to have access to all of the assessments at any point—

Senator CASH: You would not want to see a further assessment undertaken when they arrive in the regional processing centre? You would merely want access to the documentation in relation to the first assessment?

Ms Lions: No, from Amnesty's visit this week, I think it is important that the panel be able to interview the detainees personally, not just have access to their records. From my point of view, this panel has more of a broad focus of assessing the situation on Nauru rather than just individual cases being able to provide a more holistic view of the system.

Senator CASH: In relation to the role of IHAG and the fact that DeHAG is morphing into IHAG and we have not yet seen the terms of reference for IHAG: how do you see IHAG and the panel actually working, given that we do not at this stage know what the role of IHAG will actually be? It may well take up some of the roles that have been set out in this particular piece of legislation.

Senator HANSON-YOUNG: We do not report to parliament.

Senator CASH: I am not asking you. If you want me to interrupt whilst you are speaking I am very happy to, but I am actually addressing the questions to the witnesses.

Senator HANSON-YOUNG: sorry, I did not mean to be rude; I meant to help you.

Senator CASH: I understand that is a fundamental difference.

CHAIR: Senator Hanson-Young, we have all had our own time this morning prior to your arrival, and that is the way I am going to continue the rest of today's hearing.

Mr Karapanagiotidis: There does not need to be duplication. You could have a holistic multidisciplinary integrated model. It is really about first mapping out what a best practice model of health care and health standards and oversight would need to be within the detention framework that exists. And then within each of those players we need to work out in a complementary way where each person's skills and expertise is. I do not see them as having to be in conflict or having to duplicate if there is proper strategic planning and mapping out what is done with those bodies. The big picture is what does a best practice model of health care oversight look like that ensures the lowest level of harm with the best possible supervised, accessible and expedient care for people in detention and the ability to have those people who cannot be cared for n detention released expediently into the community or appropriate community care.

Senator CASH: Ms Lions or Ms Scott, do you want to provide an answer?

Ms Lions: My understanding is that the IHAG reports to the minister or the department and that the proposed medical panel would report to the parliament. For us, there is a real issue of accountability and making sure that the information is being presented to the parliament and to the public.

Senator DI NATALE: This bill was drafted at a time when things were quite different in terms of refugee policy. We have now got more people arriving; we have had a clarification around the no disadvantage test, where I think the minister outlined that it may be appropriate to keep a young person in detention for five years; and we

have now seen a number of hunger strikes and so on. So things have evolved since the announcement of this bill. Does that strengthen or weaken the argument for ensuring that we get an independent inspectorate type function through the health panel?

Ms Scott: I definitely think it strengthens it. My personal experience of detention with minors who were there for, on average, a year and adults who were there for two years is that it was already quite dire. If there is going to be a five-year time frame it even more important that it be implemented—and very quickly. In terms of my own personal expertise, I am not quite sure when an IHAG and all that sort of stuff is going to be finalised. But the people are in offshore processing centres already—it has already started—so we need something in there quickly.

Mr Karapanagiotidis: The critical thing is that you cannot rely on the existing contracted health providers to provide that oversight, because they have a fundamental conflict of interest. They are being paid by the government to provide a service, not to identify for the government how to release people into community care or identify those people who cannot be cared for. You need an independent oversight and, most critically, you need it from the beginning point to the endpoint. It is not about what people are like when they first present, even though you need to identify people who should not be there in the first place; it is about what happens six months down the track, two years down the track or three years down the track. As people continue to deteriorate and self-harm, what happens to these people beyond bandaging them up and bring them back? People attempt suicide and they bandage them up and bring them back. You need independence to be able to say that these people cannot be brought back into detention, they must be released; and that must be tabled before parliament to show some genuine accountability and transparency.

Senator DI NATALE: Have any of you in your individual capacities made recommendations and approaches to the department on the specific issue of access to health services, design of health services and so on? If so, what response have you got and what sorts of changes have you seen in response to those recommendations?

Mr Karapanagiotidis: Over the years, we have made many a submission to the department about really fundamental things—even the need for expedient medical care and proper resourcing of medical staff. But the big issue is that, when people get released from detention, they should be released with a medical discharge summary so we know what medicines they are on and what conditions have been diagnosed. Almost all of that seems to have fallen on deaf ears.

Senator DI NATALE: Are you saying people are being released from detention into the Australian community who may be on medication or have a significant past medical history and none of that information is provided to a health practitioner?

Mr Karapanagiotidis: It is standard practice. We deal with a lot of them in our health service. Some do—it is hit and miss. It went from none at all. I remember that about seven years ago we wrote a report about this which was called 'Dumped at the gate'. When they present to our centre we ask them what medication they are on and what their diagnosis is. The majority of them have no idea and no documentation—not even something as simple and common sense as that.

Ms Scott: I would second that as well, from working in community detention and in the committee assistance support program. You very rarely get any health records sent through. Some people might come out with a bunch of medication and not really understand what it is for. In terms of transferring the duty of care, it is very tricky for workers on the other side to figure out what to do with clients.

Mr Karapanagiotidis: It is standard practice.

Ms Scott: Absolutely.

Senator HANSON-YOUNG: Ms Lions, the government's response would be that, if we allow organisations like Amnesty International to go and do inspections such as what occurred this week in Nauru, why would we need to set up a statutory body to do that as well? What is your view on that? Do you think it is sufficient to leave it to non-government organisations like your own?

Ms Lions: Not at all. While Amnesty definitely has a role in highlighting some of the human rights issues and observing conditions, we certainly do not have the medical expertise that a panel like the one proposed would have.

Senator HANSON-YOUNG: When your colleagues were on Nauru earlier this week, there were reports of people with skin conditions because of the bad conditions in the tents and the beds that they are sleeping in—the wet, damp and humid conditions. Where do you go when that happens and do you have any power to make sure those problems are addressed properly?

Ms Lions: Where do we go with that information?

Senator HANSON-YOUNG: What do you do with that information?

Ms Lions: We do a number of things. Obviously we release the information publicly so that medical organisations are aware of it, and we also make representations to the minister and other members of parliament. I really would like to provide more information about Amnesty's visit to Nauru this week but unfortunately my colleague just arrived back last night so—

CHAIR: I am trying to get people to focus on this bill. We have got lots of different stories about what is happening in all of the detention centres but we have got limited time. So I really want people in this inquiry to tell me what is good about this bill. If we as a committee we were to recommend it, should it stand like this, or be amended, or is this not the way to go at all?

Senator HANSON-YOUNG: I do not think my question was irrelevant. I am asking about health conditions that an independent NGO has seen and raised concerns about. Have you got sufficient ability to deal with those issues that you have seen that would make the role of this type of body defunct?

Mr Karapanagiotidis: No. I will give you a very practical example. For a non-immigration cleared person to be released from detention because our organisation has concerns about their physical and mental health, if I went out there, as I have done, and got five independent psychiatrists to assess this person as an imminent suicide risk if they remain in detention, and then we ask for them to be released into our care with a total community care plan in place, that would be deemed an invalid application and would not be considered. You would have to try and force the government to appoint its own independent medical specialists, which there is no timeline on and which you cannot force them to do, to assess whether a person can be cared for in a detention environment. I have had hundreds of examples where it takes years of back and forth to get people assessed just to be released, even though I have got a handful of reports saying that two years earlier. That is a perfect example of the failure of the system and our ability, even when we have independent medical advice, to be able to trigger, lobby for or enforce the release of anyone. It relies entirely on whim—the discretionary non-enforceable powers of the parliament to appoint a specialist when they deem it is appropriate and when it suits them.

Ms Lions: I would see the panel as another avenue for reporting so that there is a role for organisations like Amnesty and we have avenues to report on that information. This would be another way to account for what is going on there.

CHAIR: I want to ask each of you the same question. When we had the infamous Palmer inquiry following the Cornelia Rau incident, Mr Palmer recommended in his report that there be an immigration detention health review commission. I guess the name of the body is irrelevant, but the suggestion was that it would somehow sit with the Ombudsman and have similar powers. When I read this legislation I am having a little bit of trouble trying to find out exactly where this independent committee would sit. It might be resourced or auspiced by DIAC or the immigration minister. What is your view about where you see it sit in the structure? Is it with the Ombudsman as an independent commission working alongside him on his reports, do you see it as a subcommittee of the minister's advisory committee, or do you see it working with the Human Rights Commission? Or none of the above?

Ms Lions: I am not sure I can comment on that. I am not sure it is a matter for us to decide where it sits, but the main thing for us is that—

CHAIR: You think we should have something.

Ms Lions: We should have something and it should be genuinely independent.

Mr Karapanagiotidis: I think it should stand alone. If it comes within the Australian Human Rights Commission, it will not be taken seriously because the government does not take its own Human Rights Commission seriously. If it sits within the Ombudsman, the Ombudsman is already underresourced and a toothless tiger. I think it should sit independently of all.

Ms Scott: In my position, I do not really have the expertise to answer that properly. I would just stress that we would like to see the panel as being independent.

Senator PRATT: My question goes to whether this bill has the right form of independent oversight for immigration detention, when drawing comparisons with other independent inspectorates that exist in some states—for example, for the prison system. I do not know if it passed the parliament or not, but I know that New South Wales has an Inspector of Custodial Services. Western Australia has had an Inspector of Custodial Services for some time. They are independent organisations. They seem to be able to go to questions of health but also a range of broader questions about contract standards, detention standards and whether policy is being properly implemented. So the emphasis in the arrangements like that seems quite different to what is in the bill before us, which seems to have an emphasis on health, which is not unjustified, and an emphasis on the individuals within

the system. I would ask you, if you were putting forward legislation about the independent oversight of immigration detention, what that would look like.

Ms Scott: In the submission from Hotham Mission we said we would also like to see a human rights perspective in there. I suppose that is quite similar to what you are saying. It would be a broader assessment of detention.

CHAIR: So it should not just be about health, from your perspective?

Ms Scott: Not just health. There are a lot of other factors that affect health as well.

Senator PRATT: But there is a difference between saying we want to take a human rights perspective and having someone with the power to point out systemic issues from a management point of view who might ultimately influence both health and human rights issues. So it is a matter of emphasis and focus in the management and auditing arrangements.

Mr Karapanagiotidis: You need both. You need the specialisation and expertise to deal with the massive health and mental health issues. There is a real value in having this power and having this panel and this oversight. Separate from that, you need something like what we have in Victoria with the Office of the Public Advocate and the Community Visitors program. The community visitors have unfettered access and a statutory power to access any place at any time. Those things are tabled in parliament. The Office of the Public Advocate can identify issues across the public psychiatric and intellectual disabilities system. You really do need a body that is able to have that holistic oversight as well, because access to justice, access to information and access to other care and services in a detention environment are all things that profoundly impact on people's health and mental health.

CHAIR: I do not think we have any other questions for the three of you. We have run out of time, anyway. Thank you for your time this morning.

TRIGGS, Professor Gillian, President, Australian Human Rights Commission

[10:50]

Evidence was taken via teleconference—

CHAIR: Welcome once again, Professor Triggs, to the Senate Legal and Constitutional Affairs Legislation Committee.

Prof. Triggs: Thank you very much indeed.

CHAIR: We have a submission from the Australian Human Rights Commission which is numbered 18 for our purposes. Would you like to provide us with some opening comments?

Prof. Triggs: I do have some opening comments which will I try to keep as short as I can; basically, as you said, you do have our written submission. Thank you very much for the opportunity to appear before the committee this morning. The Australian Human Rights Commission welcomes the opportunity to comment again on the Migration Amendment (Health Care for Asylum Seekers) Bill. We support the bill, as we have set out in our written submission.

The commission has repeatedly raised concerns about the health and mental health impacts of prolonged and indefinite immigration detention, particularly where persons who are detained have pre-existing vulnerabilities, including those of children or survivors of torture and trauma. We are also concerned about those occasions where detention occurs in a remote location, including offshore and third-country processing arrangements. It is well established that holding people in immigration detention—particularly for prolonged and indefinite periods under remote, climatically harsh and crowded conditions—can have devastating impacts on mental health and physical health.

With respect to the current arrangements the commission holds serious concerns about the length of time that asylum seekers and refugees could potentially stay in designated regional processing countries. We are concerned that the long-term detention of asylum seekers in Nauru, Papua New Guinea or other regional processing countries could amount to arbitrary detention and could once again detrimentally affect their physical and mental health. Indeed, there are public reports which suggest that some of those held on Nauru are already experiencing significant deteriorations in their health and mental health.

On a recent visit that I made with commission staff to Christmas Island we observed that there have been a number of improvements in the delivery of health services to the people held there. However, many told us that the possibility of being transferred to a third country for processing was causing them very significant anxiety. They expressed concern about the length of time that they might be required to stay in a third country and about the conditions in which they were living. Their primary concern was about the indeterminate nature of their stay and the fact that, at that time, the processing of their claims was not going forward. Several people said that they felt the situation was causing them depression. One person said:

Every night we sleep for one or two hours. Then we think of Nauru. We came here as asylum seekers. We've escaped from one death and will be taken to another.

Under international human rights standards all people have a right to the highest attainable standard of physical and mental health. Each person in detention is entitled to medical care and treatment provided in a manner that is culturally appropriate and of a standard commensurate with that provided in the general community. This should include preventive and remedial medical care and treatment, including dental, ophthalmological and mental healthcare where necessary. Each person in immigration detention should also be entitled to obtain a second medical examination or opinion where appropriate.

With respect to the Migration Amendment (Health Care for Asylum Seekers) Bill, the commission supports in particular the establishment of an independent expert panel of multidisciplinary health professionals to monitor, assess and report publicly at regular intervals on the health of asylum seekers who are transferred to designated regional processing countries. We do so on the grounds that regular independent monitoring is essential to ensure compliance with international legal principles and accepted human rights standards, which are of course the basic legal benchmarks upon which the Australian Human Rights Commission operates. Independent monitoring should include areas of health and mental healthcare. We believe that if independent monitors can report publicly on their findings there will be a significant increase in transparency and accountability.

The commission also recommends that the mandate of the panel required by the bill be expanded to include the health of asylum seekers. We should now add recognised refugees who are in Australia and who are liable to be transferred to a designated regional processing country and those who are undergoing a transfer to or from a

designated regional processing country or are in Australia having been returned from a designated regional processing country for reasons other than being granted a protection visa.

In essence, the commission has recommended that the mandate of the panel include all asylum seekers and recognised refugees who are liable to transfer to a designated regional processing country, irrespective of whether they are actually in one of those respective regional processing countries. That includes those detained in Australia and those who have been released into the Australian community on bridging visas. I might add here that we see this as an extremely welcome aspect of the minister for immigration's recent announcement. We would also include people who are in transit to or from regional processing countries and people who have been returned to Australia for a temporary purpose.

In making this recommendation to you, I do recognise that the scale of the population has increased substantially since our submission was lodged and therefore there are very serious practical challenges. However, we believe that basic human rights require that some form of independent monitoring of this range of people affected by the migration processes should be included.

I also note that the commission shares the view expressed by previous inquiries that there is a need for a more comprehensive and independent monitoring of health and mental health services across Australia's immigration detention network overall. In the view of the commission, the body that undertakes that function should report publicly on its findings and, of course, should be adequately resourced.

In summary, the commission is of the view that there needs to be a rigorous, independent and ongoing monitoring of the delivery of health and mental health services in immigration detention facilities on the Australian mainland, in Australia's excised offshore territory and in third countries to which Australia has transferred asylum seekers for the processing of their claims for protection. The commission is also concerned about whether asylum seekers released into the community on bridging visas without work rights will have their healthcare needs adequately met. We are of the view that this, again, should be subject to independent monitoring and public reporting. Thank you very much.

CHAIR: Thank you, Professor Triggs. I am going to start with two questions for you. Some submitters have put to us that this panel or commission, whatever it is called, should have its membership extended to include someone with expertise in human rights. What is your view about that? Should it simply just stick to being a panel of health experts?

Prof. Triggs: Depending on the resources and the efficiency of the commission, it would be extremely helpful if a member of the commission had some reasonable competence and understanding of international human rights law. For us, it is really our lodestar. For statutory reasons, it is what we base all of our activities on. One of the reasons I would encourage you to make a recommendation in relation to this is that so frequently we find in our work here at the commission that we are met with the answer, 'Well, that's not what Australian domestic law provides.' Our benchmark provisions are international human rights treaties that may not have been implemented directly into Australian law. With the scrutiny process that you would be aware of and other increased awareness of international human rights, it would be very helpful if a commission member were at least competent in this area.

CHAIR: My second question to you is: where does this body of experts fit? Would they just be a stand-alone commission reporting to parliament? Should they be attached to the ombudsman as Mr Palmer recommended in his inquiry following the Cornelia Rau incident? Should they replace the new immigration health advisory committee and combine the two bodies? Do you have a view about that?

Prof. Triggs: We appreciate the difficulty. As you would be aware, the Detention Health Advisory Group no longer exists and we are really waiting to see how the immigration health advisory group is comprised.

CHAIR: Yes.

Prof. Triggs: The difficulty in relation to the Commonwealth Ombudsman is that the Ombudsman does not report publicly on its detention visits. If this new commission were to be linked to the Ombudsman office, we would certainly want to see a capacity for public reporting. I think what the most efficient way of doing this work is seriously has to be considered. My understanding at the moment, and I can certainly speak for the Commission, is that we do not have any specialised capacity in health or mental health care. While we would be very happy to have the commission—when it is set up—linked in some way with the Human Rights Commission for reasons of efficiency and management, we would clearly need some resources and technical expertise. I imagine, but obviously cannot say, that the Commonwealth Ombudsman would have a similar view.

CHAIR: Can you clarify your view that the Ombudsman does not report publicly? There are reports provided to the parliament that the Ombudsman is mandated to do for people who are held in detention for long periods of

time. There are reports dotted throughout the last few years where the Ombudsman has reported on what is happening in the immigration system.

Prof. Triggs: That is interesting because my briefing advises me that the Ombudsman does not report publicly on its detention monitoring visits, but that may be just a specific question in relation to detention monitoring and there may be a wider reporting in other areas. Perhaps I could get back to you to clarify that point.

CHAIR: Alright. There are reports tabled in the parliament regularly; the Ombudsman has a statutory authority now to actually report on and monitor people that are held in detention longer than—I am not sure—30 days. That is probably a minor issue that we need to talk about today.

Prof. Triggs: I will clarify that, but I am briefed to the effect that the detention monitoring visits are not reported.

CHAIR: Senator Di Natale, have you got questions?

Senator DI NATALE: Both of those questions were very helpful and on my list, so thank you. The intent of the bill is to be very separate from the IHAG function. I wonder if you see the need for a more independent body with oversight or what I think one of the previous submitters described as an inspectorate function versus a more functional role that is currently performed within the department. Is it important to achieve that sort of monitoring because, in a sense, the only other alternative is for that function to be performed by the people who are actually implementing the work? Again, I think the previous submissions describe that as a significant conflict; do you agree with that analysis?

Prof. Triggs: I do in principle. My understanding is that the Detention Health Advisory Group, when it existed, was concerned that it was not able to be sufficiently independent and felt that was a serious shortcoming. So, on the basis of that information, I would really have to say that in principle the independence of the entity is critical. As you will know, that independence is critical to the activities of the Australian Human Rights Commission. I think it will add credibility to the reports and work of health care in relation to asylum seekers.

Senator DI NATALE: One of the other issues with DeHAG was that its recommendations were essentially directed at the department and at a secretary level. The advantage of recommendations being made directly to the parliament—what sort of accountability function do you think that serves? Do you think that is a significant difference in terms of the former operation of DeHAG and how this new panel would work?

Prof. Triggs: I think that would be a significant difference if that were to be achieved. Certainly, reporting to parliament gives an element of independent oversight by parliament—that is, a direct role within the democratic system. So I would see that as a very positive improvement.

Senator DI NATALE: One of the other issues we have heard about is access; the question of sovereignty and whether we would have an issue with a statutory panel having access to offshore settings. I imagine that is an issue for you, for the commission. I imagine that has been an issue for Amnesty International. I imagine that has been issue in the construction of these sites. I imagine it has been an issue right along the line. Do you see that as a significant barrier?

Prof. Triggs: To be honest I do not believe it is a barrier at all, because it is a matter of international law. Australia is legally responsible for all international activities over which it has effective control. That is a very broad statement, but, specifically in relation to asylum seekers, clearly there is an obligation to assess those claims and to ensure that basic humanitarian rights are preserved. By transferring people to an offshore facility, those obligations continue. Certainly they would continue in the specific instances that are in existence at the moment in Papua New Guinea and Nauru, where Australia is playing such a strong role in relation to assisting with legislation, training of those likely to undertake assessment and so on.

So I think as a matter of international law there is no doubt at all that Australia retains its responsibility. However, there is of course the problem that Australia might determine for itself that it will not permit the jurisdiction of its agencies to extend to offshore territories, and the Australian parliament would be more than entitled to pass legislation or to make clear that point if they chose to do so. So what we would have, if that were to be the case, would be a disconnect between the Australian law in terms of permitting a jurisdictional reach of its own entities, such as the Australian Human Rights Commission or in this case a commission dealing with mental health. You would have a disconnect between that domestic law and the international obligation. That is a disconnect that exists quite frequently in Australian law.

Senator DI NATALE: That would be a conscious decision by the Australian government to not allow that; it has nothing to do with the response from either, in this case, the Nauru government or the government of PNG?

Prof. Triggs: No. They can of course as sovereign states determine for themselves. But the question that is of importance, I imagine, for you and for parliament generally, is: does parliament want to accept the logical or the legal conclusion that Australia is internationally responsible for its actions overseas over which it has effective control and pass legislation to permit a jurisdiction of its agencies? Or does it want to fly in the face of that and say, 'No, we will not allow jurisdictional reach and these kinds of commissions or monitoring groups would not have a jurisdiction there'. I think it would be an extremely negative position to take, and it would be far better, if I may say, to deal with this on a case-by-case basis so that you do not have a head-on collision between two systems of law.

Senator DI NATALE: Thank you.

Senator PRATT: Professor Triggs, I want to ask you how this bill lines up against how other arrangements might evolve, noting specifically the government has accepted the findings of the expert panel that for the protection and welfare arrangements for people transferred to Nauru the monitoring of care and protection arrangements be by a representative group drawn from government and civil society in Australia and Nauru. I am wondering if the Human Rights Commission has a view about the overall arrangements for independent oversight of detention, noting that there are a number of proposals.

Prof. Triggs: That is right. The position of the expert panel that there should be appropriate monitoring both by government bodies and civil society is of course a general and, we would say, sensible recommendation. I would see the commission to be set up in relation to the health care for asylum seekers bill as being part of that general oversight but again we as the national human rights body and an agency of the government would see us as having a role in that oversight as well but clearly without the expertise that would be appointed to the health care commission.

Senator PRATT: I would agree, clearly the Human Rights Commission will have a role. I suppose I am concerned there would be a plethora of organisations without somebody having thought through what systemically oversight inspectorate arrangements should actually look like.

Prof. Triggs: I think that is an important point. We could end up with a fragmented response which would be unhelpful, which may be one reason why it will be invaluable to look at the commission in relation to the health care for asylum seekers being connected with the ombudsman or with the Australian Human Rights Commission so it is possible to have a more joined up response to this monitoring when it is going to take place by different entities.

Senator PRATT: It would strike me though that, even if you had all of those three bodies joined up, they do not necessarily have the same kind of function as other inspectorate services that take a more detailed, independent oversight. I am wondering if you have a view as to how those things might be married.

Prof. Triggs: To be honest I have not thought about how that could be achieved. I would certainly like to talk to my colleagues. Indeed, I am meeting with the Commonwealth Ombudsman early next week. Would it be acceptable to you if I raised this in that meeting of the relevant agencies in these areas? It might be helpful if I were to raise it with them and see if we could get some kind of agreed view as to what might be an appropriate way of responding to your question, because I do think you raise an important issue.

Senator PRATT: Thank you.

CHAIR: Professor Triggs, thank you. We have no more questions for you this morning. I thank you very much for your time and your submission again.

Prof. Triggs: Thank you very much. It was a pleasure.

Proceedings suspended from 11:14 to 11:30

ANDERSON, Ms Adrienne, Policy Officer and Solicitor and Migration Agent, Refugee and Immigration Legal Centre Inc.

FLETCHER, Mr Adam, Manager, Accountability Project, Castan Centre for Human Rights Law

MANNE, Mr David Thomas, Executive Director, Principal Solicitor and Migration Agent, Refugee and Immigration Legal Centre Inc.

PENOVIC, Ms Tania Sandra, Deputy Director, Castan Centre for Human Rights Law

Evidence from Ms Anderson and Mr Manne was taken via teleconference and evidence from Mr Fletcher and Ms Penovic was taken via videoconference—

CHAIR: I welcome representatives from the Castan Centre for Human Rights Law, via videoconference, and representatives from the Refugee and Immigration Legal Centre, via teleconference. The Castan Centre for Human Rights Law has given a submission, which we have numbered 4 for our purposes, and the Refugee and Immigration Legal Centre's submission is No. 6 for our purposes. I am going to ask both of the organisations to provide us with some opening comments, and then we will go to questions. Who is going to go first? Perhaps I might get Ms Penovic and Mr Fletcher from the Castan Centre for Human Rights Law to start for us.

Mr Fletcher: Thank you for the opportunity to speak in support of our submission to the inquiry. In view of previous testimony this morning which has covered the facts and figures in some depth, we would like to expand on the aspects of our submission dealing with the relevant human rights standards. A preliminary issue is whether Australia's obligations under international human rights treaties extend to the processing centres on Nauru and Manus Island. The UN Human Rights Committee has said that a state party's effective control over a place is enough to enliven extraterritorial human rights obligations. In our view, the level of Australian involvement—including construction, funding and staffing of these processing centres—demonstrates this effective control. The UN Committee on Economic, Social and Cultural Rights has also said that states parties have specific obligations to ensure respect for the right to health in other countries if they have relevant legal or political influence in those countries.

In terms of the substantive human rights involved, there is some doubt as to whether protections covering detainees apply to those to be processed on Nauru and Manus. Reference to the asylum seekers as 'transferees' and to 'regional processing centres' rather than 'immigration detention centres' in the relevant instruments suggest that the government does not believe these people are detainees. However, evidence presented by Amnesty International this morning, whose representatives have visited the facility on Nauru, suggests that in practice the restrictions placed on these people have deprived them of their liberty. As such, we believe that the protections in articles 9 and 10 of the International Covenant on Civil and Political Rights, which relate to the prohibition on arbitrary detention and the guarantee of dignified conditions of detention, apply. In addition, the evident psychological harm being done to transferees, who are not being told when their refugee plans will be processed, may breach article 7 of the ICCPR regarding prohibition on torture and ill-treatment.

We understand that the first asylum seekers have been sent to Manus Island this week, and that these include families with women and children. We are concerned that exposing them to the health risks posed by drug-resistant malaria, as mentioned by the medical associations earlier this morning, may even threaten their rights to life under the ICCPR.

Finally, we believe that the regional processing operations risk breaching asylum seekers' rights to the highest attainable standard of physical and mental health under the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination Against Women, and the Convention on the Rights of the Child. The UN Committee on Economic, Social and Cultural Rights says this right entitles people to timely and appropriate health care and safe living conditions. It also requires special measures to ensure children are able to develop in a healthy environment.

States are required to fulfil the right to health by adopting measures against environmental hazards and any health threat as demonstrated by epidemiological data. The government has been aware of such data at least since the new directions in detention were announced in 2008, and certainly since the University of Wollongong study in 2010. Failure to remove vulnerable people from detention facilities in the face of significant epidemiological data is clearly contrary to article 12.

The only relevant measure taken so far to safeguard the right to health seems to be the contract by the health provider IHMS, which has always been criticised here as inadequate to address the needs of potentially thousands of asylum seekers. The Committee on Economic, Social and Cultural Rights says that a state which is unwilling to

use the maximum of its resources for the realisation of the right to health is in violation of its obligations under the covenant.

It has been mentioned that IHMS will provide a standard of care which is comparable to that of available to someone in detention on the mainland. However, in our view the standard should be that which is available to the general public, because Australia is obliged to provide primary health care without discrimination. We believe that in all situations where people are at the mercy of the government strong oversight is the best way to ensure that the country does not breach any of its obligations. We therefore recommend that this bill be passed.

CHAIR: Ms Penovic, did you want to add anything to that.

Ms Penovic: No, that is our opening submission. I am happy with that.

CHAIR: Mr Manne and Ms Anderson, we will go to you for some opening comments.

Ms Anderson: Thank you. On behalf of the Refugee and Immigration Legal Centre we thank the committee for the invitation to appear and for the opportunity to contribute to this inquiry. By way of a brief background, the Refugee and Immigration Legal Centre has been operating for over 20 years, providing free legal assistance to asylum seekers, refugees and disadvantaged migrants. We specialise in all aspects of refugee and immigration law, policy and practice, and we provide immigration advice and assistance to over 4,000 people each year. Relevant to this inquiry, we have over 15 years experience with clients and remote detention locations, including past experience on Nauru during the previous regime of offshore processing. We have worked closely during this time with medical professionals who work with mutual clients and on similar issues.

In the discussion of conditions on Nauru and Manus Island we must begin by being frank about what it is we are talking about. These measures have been designed to deter or discourage people from seeking protection, and to deny to them all of the ordinary protections of Australian law that others receive if they arrive by air, whether in an authorised or an unauthorised manner. The endgame here is out of sight, out of mind, out of law. It follows that our discussions today are a question of amelioration of harm rather than avoidance of harm where breaches of rights have already occurred and continue to occur. The designations of Nauru and Papua New Guinea as regional processing countries, tabled in parliament, reflect the view that Australia's international responsibilities end when people are put onto a plane leaving Australia. With respect, in our view, and taking into account international law, it is possible to transfer people only in limited circumstances with appropriate safeguards.

Such transfers do not terminate Australia's obligation to protect against return to a threat to life or freedom or to ensure that rights under the refugee convention, such as freedom from punishment for unauthorised entry, rights to education, access to the courts and nondiscrimination, are complied with.

Moreover, it appears that the Australian government is responsible for the management of these extraterritorial detention centres and retains effective control over the people who have been taken from Australia to regional processing countries. This gives rise to a continuing duty of care on behalf of the government, as would attach in Australia. In our experience, the remoteness and isolation of regional detention centres, combined with uncertainty of processing and the indefinite nature of stay in regional countries, has led before and will likely lead again to psychological and physical harm, and suffering for the people involved.

The health and wellbeing of these people is integral to their ability to engage effectively with the refugee status determination process. Poor mental health or physical health may hinder the prospect of due recognition of refugee status. Therefore, in our view, the confinement of people who have arrived seeking protection from danger to indefinite exile far from our shores adversely impacts on Australia's ability to meet its international protection obligations, particularly against return to serious harm where people are not able to fully participate in the determination of their own status.

It is in this context that we welcome the bill and the role that it proposes to play in reporting on conditions and promoting accountability in relation to the arrangements in regional processing countries. We also view that it should be similarly welcomed by the Australian government as one means of ensuring that its legal obligations are complied with and that vulnerable people are not further and unnecessarily harmed.

CHAIR: Mr Manne, do you want to add anything to that?

Mr Manne: No.

CHAIR: I am going to start by asking you both that if this bill was actually passed, how do you see the issues of sovereignty and jurisdiction being overcome in relation to offshore processing centres? Mr Fletcher, perhaps your group might answer first.

Mr Fletcher: As has been mentioned earlier in the day there are questions about access for the inspection group. Earlier, the Asylum Seeker Resource Centre said that this should be able to be negotiated between the

Australian government and the Nauruan and PNG governments through the joint committees that have been set up. We see it as a question not of intruding on sovereignty but of negotiating with the sovereign governments of Nauru and PNG to enable this mechanism to work.

Ms Penovic: But in that sense we see it not being any different to arrangements for the Red Cross, the Salvation Army or any other relevant group in performing their role.

CHAIR: Mr Manne or Ms Anderson.

Mr Manne: The question that you pose relates fundamentally to what is going on here. What is going on for practical and legal purposes is, quite clearly, in our view, extraterritorial processing. People are being transferred to Nauru, to a country that simply does not have the capacity to manage the key aspects of the undertaking—that is, transferring people to Nauru, ensuring that they are housed and cared for; processing claims for protection; and, indeed, providing for a whole range of other services such as security, health care, case management and the management of contracts and so forth. Nor does Nauru, it is clear, have capacity to provide for a timely resettlement—or indeed local integration—of people found to be refugees. In that sense it is quite clear that we are looking at a situation where the Australian government is essentially exercising effective control over the arrangements, which brings with it a legal responsibility and indeed, we would say, an ethical responsibility to ensure that people are humanely treated, that they receive fair processing of any claims for protection, and that they be resettled within a timely period.

CHAIR: Sure, but given all of those comments, which we know and which probably will not change, my question really was: how do you overcome the jurisdictional issues when it comes to sending a committee, a body or a commission such as this to an offshore processing centre?

Mr Manne: How you overcome them, presumably, is in the same way that they have been developed, which is through further negotiation with Nauru, or Papua New Guinea, as part of the transfer arrangement. The transfer arrangement has already overcome, it appears, certain issues concerning sovereignty, such as transferring people to Nauru and setting up tents for people to live in at the moment, and so forth. We would see it as a necessary extension of the arrangements that have already been undertaken, rather than overcoming any possibly insurmountable obstacle. Were that not to be the case we would be confronting a situation where the Australian government was expelling people from its shores to another country without being able to provide for their care.

CHAIR: The second question I have for both of you is: should this be an independent body? Should it be attached to the Ombudsman? Should it be an advisory group to the minister's advisory group? I am looking at the legislation and trying to picture where this new body would fit in the structure. How do you envisage it would operate and where might it sit in the structure?

Mr Manne: We see this oversight committee needing to be totally independent. The current ministerial advisory council—MCASD—is not an appropriate body to conduct this oversight function. Rather, a properly independent oversight committee should be established with people on it who have relevant expertise in the areas that we are talking about. Previously, there have been independent consultative groups in relation to development of the regional protection framework. The current status then is unclear and we have to say that at the moment we remain very concerned about precisely what mechanisms are in place in relation to ongoing issues about the care and treatment of people in Nauru and who is responsible at the moment for oversight of their situation. Which independent bodies or people are responsible for that?

Ms Anderson: In addition, it is particularly important in the context where the only way for an unwell person be taken back from Nauru or Papua New Guinea to Australia is a personal discretion of the Minister for Immigration and Citizenship. The provision of frank, independent advice in this regard is important.

Mr Manne: I briefly add that any oversight mechanisms need to be fully transparent and accountable and that, at the moment, it is very unclear whether any of the oversight—to the extent that there is any—is properly transparent and accountable. That remains a real concern.

Mr Fletcher: I endorse the comments we just heard. I add that international human rights law is primarily concerned with the effectiveness of the measures taken to ensure respect for the rights which are guaranteed in the relevant instruments. So we see that an independent body which has some sort of public reporting requirement is likely to be more effective in achieving good health outcomes than the internal bodies, such as the IHAG—which, we understand, has not yet been formed—because, as Mr Manne said, the transparency and accountability of such an independent body which reported publicly would be far greater.

Mr Manne: I would like to add one further comment to this very important point about the independence here. It is extremely important that bodies that are involved in central aspects of the implementation of this policy are not also involved in at the same time or charged with oversight functions. We remain concerned at the

moment that this is not clear. It is far from clear that those functions of implementation and oversight have been separated out to avoid any possible blurring of lines—or worse.

Senator DI NATALE: That is certainly the intent of the bill. We currently have a situation where the police are effectively policing themselves—I suppose that is the issue—and we have heard submissions describe that as a serious conflict. So that is absolutely the intent; do you have anything specifically you would like to add that would ensure that we make that clearer in the legislation?

Mr Manne: We think it is sufficiently clear at present.

Senator DI NATALE: That is good. We heard that DeHAG, who are no longer functioning, made a number of recommendations and that effectively they did not go anywhere. None of the recommendations made by this panel would be enforceable; they would be recommendations made to the parliament and directly to the minister, and obviously they would be public. Do you think that that adds another layer of accountability? Should anything further be done to add some level of direction towards the minister?

Mr Fletcher: As I said before, I think it certainly does add another layer of protection. It could possibly apply some kind of public pressure to the minister if the inspection group's reports were public. I should also say that Australia is currently on the path towards the ratification of the optional protocols to the convention against torture, which involves setting up what is known as a national preventive mechanism of inspection bodies which visit all sorts of closed environments, including immigration detention and processing centres. The whole idea of that mechanism, once it is set up, is to have independent visiting and reporting on places like that. We think that, for the specific purposes of inspecting offshore processing centres, this would fit in with that regime when it is put into place.

Senator DI NATALE: Do you have anything further to add, Mr Manne or Ms Anderson?

Mr Manne: Yes. We believe that any recommendations or report of recommendations by the oversight committee should also include the requirement that the minister for immigration respond within a short time frame to those recommendations, that that response be tabled in parliament and that, as part of that response, it also include a statement of human rights compatibility—that is, compatibility with the human rights obligations that we have signed up to under the refugees convention and other international human rights treaties to which Australia is party.

Senator DI NATALE: Thank you. Most of my questions have already been addressed. I would just ask you to comment very briefly on whether you think the change in circumstances and government policy over recent weeks have strengthened the case for this panel?

Ms Penovic: At the moment we are not seeing a manifestation of what was envisaged by the expert panel. The recent Amnesty International report on Nauru gives rise to grave concerns and just highlights the urgency of this bill and the imperative, in my view, that is passed. The unfolding events have certainly given rise to great concern and highlight the timeliness of your initiative.

Mr Manne: We would like to add that, yes, what we are seeing at the moment, the recent evidence in the last few weeks, essentially underscores the fundamental importance of this bill being passed urgently and implemented urgently, given that what is clear is that even the recommendations of the Houston panel do not appear to have been properly or faithfully implemented thus far on Nauru. Every day is another day of damage to those vulnerable people who have been sent from Australia to Nauru. As part of that, what is clear is that in many respects the rush to expel people from Australia to Nauru, subsequent to the panel report, has involved essentially sending people before proper arrangements have been put in place, which remains a real concern.

Australia retains the duty of care for these people, and in expelling them to Nauru it is doing so conscious of the lasting harm it is likely to cause to people. That is indicated by all the expert and independent evidence in relation to sending people to these types of situations and leaving them in limbo, possibly for years, in a situation where the duration of their stay still does not even have a time frame to it because it is based on the so-called no advantage test—that is, a test without any benchmark attached to it because the UN refugee agency itself says there is no such average waiting time as that test presupposes. In those circumstances we know that there is likely to be severe psychological and physical harm inflicted upon many innocent people. In that context it is crucial that any possible steps, such as those proposed in the bill, which could mitigate likely and foreseeable harm are acted upon urgently.

Senator PRATT: I have one question for the Castan Centre for Human Rights Law. I know that you have done some work on implementing human rights in closed environments. You have endorsed the bill that is before us. But it does not some to provide an independent inspectorate role in a more holistic sense that might pick up a range of broader issues and provide more detailed monitoring. It is a panel that can pretty much do what it likes,

but there are—as you would be aware—a range of quite structured ways in which independent oversight could be done. I am interested to know what you think it should look like in an ideal sense, noting that the government needs to implement the recommendations of the expert panel, which includes—and I am not sure if this the correct terminology—arrangements such as 'monitoring of care and protection by a representative group drawn from government and civil society in Australia and Nauru'. I note that there is nothing about the state of independence of such monitoring in that particular statement. I wondered if you could draw the two together.

Mr Fletcher: I could not agree more that in an ideal world the inspection body would be broader. I have to say that we endorse earlier comments from the Australian Human Rights Commission and the Hotham Mission Asylum Seeker Project that the body should include someone with expertise in the relevant human rights law as well as other experts. But we also recognise that this bill intends for the body to serve a specific health related function and that it was not conceived as an immigration detention inspectorate in the broader sense. While we would like one of those we understand that that is not on the table at the moment.

Ms Penovic: And there is an imperative to act urgently, given the situation in Nauru currently and the current removal of asylum seekers, including families, to Papua New Guinea.

CHAIR: We do not have any other questions for the four of you this morning. Mr Manne and Ms Anderson, thank you for your submission and your time. Mr Fletcher and Ms Penovic, thank you for your submission and your time as well.

DOUGLAS, Mr Kenneth, First Assistant Secretary, Detention Infrastructure and Services Division, Department of Immigration and Citizenship

PARKER, Ms Vicki, First Assistant Secretary, Expert Panel, Implementation, Refugee, Humanitarian and International Policy Division, Department of Immigration and Citizenship

[12:04]

CHAIR: I now welcome officers from the Department of Immigration and Citizenship. We all know the resolution regarding officers and opinions on matters of policy. The department has provided us with a submission, and we thank you for it. It is no. 19 for our purposes. Do either of you want to make an opening statement?

Mr Douglas: No, thank you.

Senator CASH: Thank you, Mr Douglas and Ms Parker. Thank you for your submission. I want to initially turn to the comments made by the department in relation to access to asylum seekers. The department's submissions highlights the lack of procedures in the bill to enable the panel to access asylum seekers in regional processing countries. In particular, the department's submission states: 'The bill assumes that the proposed health advisory panel will be able to carry out a number of activities in or in relation to a regional processing country. However, the bill does not acknowledge that this will necessarily depend on the consent and the agreement of the government of the relevant regional processing countries.' What issues do you see associated with the failure of the bill to address that?

Mr Douglas: We are very conscious that in establishing the regional processing centres that they are established within separate sovereign countries. Each time anybody, whether it be a staff member of the department or indeed somebody being transferred to the centre, is seeking permission to enter the country they need to be granted a visa and they need permission to access a centre. It is a shared arrangement. The challenge we were presenting to the committee for it to consider was the coverage of Australian law in relation to a separate sovereign country.

Senator CASH: I put the department's submission to two of the witnesses earlier today. One of the witnesses from the Asylum Seeker Resource Centre responded to that issue by saying, 'The department basically negotiates this type of access all the time; this should be no different.' Is it as simple as that?

Mr Douglas: I do not believe so. We do arrange significant access throughout the Australian detention centre network for a whole range of scrutiny groups. But that is in Australia, where we have authority. What we are posing for the committee to consider is how that might be applied under Australian legislation with a foreign country. For example, over the last three weeks or so, there have been visits by both the Australian Red Cross and Amnesty International. Both of those visits required the consent of the Nauru government. We did not take their agreement for those visits for granted or lightly. We sought their agreement in the first instance.

Senator CASH: One of the other issues that was raised this morning was the fact that current bodies do not necessarily have access to contractual arrangements between, for example, the department and IHMS. I would assume that that is for the reason that I am often given at estimates hearings. We do not necessarily get to see the contracts either. It was stated that the panel should be given access to this type of information. Would this particular type of panel be able to be given access to contractual information that even the Senate has difficulty obtaining?

Mr Douglas: My understanding is that just about all of the contracts we have in place have public release versions that have been issued to the Senate and therefore more broadly to the rest of the community.

Senator CASH: But what about the entire contract?

Mr Douglas: There are certain commercial-in-confidence matters, obviously, that go to us being able to effectively able to operate the contract way in partnership with those particular agencies. My answer would really be that it depends what information was being sought and the purpose for which it was being sought. We would try and find a way to accommodate that need.

Senator CASH: Another issue that was canvassed with some witnesses earlier today was in relation to section 5, clause C of the proposed legislation, which states:

(5) In performing its monitoring and assessment functions, the panel may:

… … …

(c) assess the health of an offshore entry person when he or she first arrives in a regional processing country;

The issue that appeared to arise in a discussion concerning what that actual means was that there does not appear to be adequate procedures in place to allow access to the health records of asylum seekers when they get to a regional processing country. What is the current procedure in relation to access to an asylum seekers health records by, say, IHMS?

Mr Douglas: IHMS, as you know, is a provider of health care and the onshore detention network. IHMS is the organisation providing health care in both Nauru and Manus, and they are connected up to the same computer system—Chiron, as it is known—which enables them to get access to the healthcare records.

Senator CASH: The evidence given was that the system was clumsy, but I assume you do not need an oversight panel to implement what could just be a change to a system. Potentially, if there were problems with the system and access to the system you could just improve the systems.

Mr Douglas: IHMS is in the process of developing and implementing an improved system purely for that reason. However, most of the people involved in the processing centres that have been established in Manus and Nauru are experienced IHMS employees who have volunteered to move there from centres in Australia. Consequently, their networks are very effective and the level of supervision and clinical support they are provided is excellent. The senior physician, for example, has extensive experience on Christmas Island, and we are confident that the professionalism and the business methods that are in place are sufficient to overcome most of the obstacles. Nobody can guarantee everything, of course, but most of the obstacles can be overcome.

Senator CASH: We had another discussion this morning about the role of DeHAG—which was operational from 2006 into 2012 and which is morphing into IHAG—and the role of IHAG. Will IHAG have a role to play in oversight of the provision of health services in relation to regional processing countries?

Mr Douglas: IHAG has been established by the incoming secretary, taking advantage of the lessons learned over the course of the last six years of its operation. The secretary wants that new group to take a broader, more systemic look at health policy and service delivery across not only the detention environment but also the whole of the immigration environment. Many drafts of the terms of reference have been exchanged with DeHAG members. I would not want to speak on behalf of that incoming group and the advice it might want to put to the secretary about the arrangements it would like to put in place in relation to regional processing. In addition, there are separate oversight arrangements which have been established in conjunction with the respective countries—and I will ask Ms Parker to talk about that—which include subcommittees that are looking specifically at health matters.

Ms Parker: The administrative arrangements with both Nauru and Papua New Guinea are in the process of being finalised, but both of those documents contemplate having a joint advisory or oversight committee to look at the operations, the welfare of transferees, the management of the centres et cetera. At the moment we are in the process of establishing an interim joint committee to advise the minister. That will run for about six months and will be able to advise the respective governments of what is happening on the ground in that six months and also of permanent terms of reference for a permanent advisory committee for each regional processing country.

CHAIR: How many health experts are on that committee?

Ms Parker: I will give you a run-down: the committee is being chaired jointly by Dr Wendy Southern—she is not a medical doctor—

CHAIR: I just want to know how many health experts are on it.

Ms Parker: Paris Aristotle would be one, Nicholas Procter—

Senator DI NATALE: What about mental health?

Ms Parker: Mental health experts?

CHAIR: No, health.

Senator DI NATALE: Including mental health.

Ms Parker: I will go to that area in a minute.

CHAIR: How many health experts on that committee?

Ms Parker: Three at the moment.

Senator DI NATALE: Can you name those people?

Ms Parker: Mr Paris Aristotle—

Senator DI NATALE: Paris Aristotle is not a health expert; he has worked with survivors of torture. Can you please just name the people individually so that at least we can make our own assessment?

CHAIR: Who are the people in that group who have been put there because of their knowledge in a health profession?

Ms Parker: I would include Paris Aristotle in that—

Senator DI NATALE: What are his health qualifications?

Ms Parker: who has had many years in torture and trauma counselling.

Senator DI NATALE: But what are his health qualifications?

Ms Parker: I am not aware of them.

Senator DI NATALE: Well, I am; he does not have any.

CHAIR: That is what I am asking you, Ms Parker. Who is there because they are an expert—

Ms Parker: Health qualified.

CHAIR: or who have eminent qualifications in either a medical or a psychological area of health?

Ms Parker: Professor Nicholas Procter, Chair of Mental Health Nursing, University of South Australia and member of the minister's council; and Dr Maryanne Loughry—I am afraid I do not have her qualifications with me, unfortunately.

Senator DI NATALE: Are you sure she is a medical doctor?

Ms Parker: She is a psychologist, I believe.

CHAIR: So we have got two psychologists in that group, but perhaps no-one from the AMA or a GP related person.

Ms Parker: Not at this stage.

Senator DI NATALE: No psychiatrists?

Ms Parker: No.

Mr Douglas: The immigration heath advisory group does contain medical representatives; they are nominated by their respective associations.

Senator DI NATALE: But that is a separate group.

CHAIR: Mr Douglas, when you said that numerous drafts have been going to and from the department to DeHAG members, is that to all of the members of DeHAG, the chair or one representative?

Mr Douglas: I can recall at least two occasions where the acting secretary has attended DeHAG meetings and met with all of the members of DeHAG who attended those meetings to discuss the various drafts of the terms of reference.

CHAIR: So we are only talking about two meetings here—not exactly, as you would put it: 'Terms of reference have gone to and from DeHAG members'?

Mr Douglas: The terms of reference were, from memory, provided if not before the first meeting then tabled at the first meeting. The acting secretary asked for responses and opinions on those drafts and then returned at a subsequent meeting to discuss the responses he had had and to offer the opportunity for further discussion on those drafts.

CHAIR: So that has occurred only twice?

Mr Douglas: At least twice. As I said, I have not been able to confirm that number since hearing that testimony this morning.

CHAIR: If we go back to Mr Palmer's report—right back to the now infamous Cornelia Rau episode in 2005—can you take on notice for me the number of reports from Mr Palmer in relation to Cornelia Rau and Vivian Solon; all of the parliamentary reports that have recommendations regarding health outcomes, advice or commentary; and which of those have or have not been put in place?

Mr Douglas: I will take that on notice—

CHAIR: Thank you.

Mr Douglas: though I make the point that seven years is a long time in an area that has a heck of a lot of scrutiny.

CHAIR: That is right.

Senator DI NATALE: It is a very long time. That is why we are having this discussion around this bill, Mr Douglas.

CHAIR: Thanks very much, Senator Di Natale; that is correct. Mr Palmer recommended, in 2005, that an immigration detention health review commission be established to carry out external reviews of health. I know from my experience in this area, having been on this committee for all of that time, that that recommendation was not picked up or endorsed by the government at the time. Is that right?

Mr Douglas: I would not know; I would need to take advice.

CHAIR: All right. I would like that analysis done, if that is also possible. In your submission you have written:

> The Minister has requested that relevant members of his Council on Asylum Seekers and Detention take on, as an interim measure, an advisory role relating to transferees under off-shore processing arrangements that is consistent with that described in the Expert Panel's Report.

You go on to say:

> This will include advice on the practical management of all services to transferees, including health services.

It is clearly not adequate though, is it, would you think, because only two of those people have any sort of health expertise and they are psychologists. As the department, how are you or the minister getting advice about what is actually needed in these offshore processing centres for the holistic health of these people, particularly their medical health?

Mr Douglas: We have a contract in place with a healthcare provider that gives us quite a deal of—

CHAIR: That is not going to answer my question, Mr Douglas. I know that you have asked IHMS to run the service once it is in place. I am asking you: what medical advice are you taking and from whom before that service is put in place in those offshore processing centres? Who provided you with advice that it is a really good idea to put 14 people in a canvas tent in the humidity of a place like Darwin where I live? Who advised you that it would be a good medical outcome for those people? When I fly home tonight, I sure as hell do not want to sleep in a tent in 95 degree humidity, let me tell you. Who would have advised you that that is a good way to go?

Mr Douglas: I am not too sure that I can point to any specific advice that addresses that particular question.

CHAIR: So my question to you is: in setting up these offshore processing centres, before you contracted or had an agreement with IHMS did you have any medical expertise advice on the best way to handle people living and sleeping in humidity, for example?

Mr Douglas: When we were putting in place the healthcare arrangements, we consulted and discussed with IHMS, our healthcare provider, and sought a proposal from them about what they considered was necessary to support healthcare provision for people living in those circumstances, and we have responded accordingly by putting contractual arrangements in place to deliver that care.

CHAIR: So you got advice from the people who would carry out the contract, not independent medical advice from experts in the two countries then?

Mr Douglas: The IHMS is a subsidiary of a major international healthcare provider, FOS International, which has vast experience throughout the world in providing health care in quite remote circumstances. In approaching them to provide the health care, we asked them to give us their advice on what they considered would be necessary given the circumstances in which people would find themselves on Nauru and on Manus Island.

CHAIR: And their advice to you was that living in a canvas tent in the humidity that is expected in the tropics would be fine?

Mr Douglas: We put to them the living arrangements which the Defence Force had installed at the government's request and we took them on scoping visits to inspect the facilities that were being put in place at the time. Then we asked them to give us their proposal on what they considered was necessary to support effective health care in those environments. Not surprisingly, the arrangements differ given the different climatic conditions and public health scenarios of the two different countries.

CHAIR: And you are telling this committee that they advised that the tent situation would suffice?

Mr Douglas: No, I am answering your question, which was about the healthcare arrangements that are put in place for the people who are put in those circumstances.

CHAIR: My next question then is: did they advise you that the tent arrangements on Nauru in that weather and under those conditions would be an effective way of managing people's long-term health outcomes?

Mr Douglas: No, neither did we ask them that question.

CHAIR: Why not?

Mr Douglas: The government took the decision that a temporary facility would be constructed by the Australian Defence Force, which was tent based and supported by refurbishment of the existing buildings. That was the circumstance that we were working within.

CHAIR: How long will these people be in those tents? What is temporary?

Mr Douglas: The construction process for the permanent facility at the Topside site at Nauru has commenced. The company has been contracted and has undertaken its preliminary survey work. It is in the process of acquiring the necessary buildings and the workforce. We expect that within a few weeks the first of the permanent residential buildings will arrive and will be assembled onsite; we will then be able to progressively install more buildings over the course of the coming months, which will gradually enable people to be shifted out of the tents.

Senator DI NATALE: To try to cut to the chase, how long have we had mandatory detention? Twenty years?

Ms Parker: It was the early nineties, I believe.

Senator DI NATALE: And we have had submission after submission today unanimously saying that we have made recommendations to the department through various bodies about how to better improve the access to health care and the treatment of detainees in order to improve their long-term health. We have heard about delays in assessments and delays in the response to people in acute distress. When they do respond, we have heard, they are responding inappropriately, putting people with acute mental illnesses in confinement, detaining them and not giving them access to appropriate medical care. When they are finally discharged from these facilities they are not being discharged with a discharge summary or a medication list—they are fronting up to their medical practitioners with no idea of what their health status is, despite some of them having complex medical histories. And you are saying to us today that it is okay: 'It's all fine, we're on top of it. It's under control.' Is that what you are saying?

Mr Douglas: I do not believe I said anything of the kind.

Senator DI NATALE: Let me ask you, are you satisfied with the detention network in terms of access to health care and ensuring that the long-term health outcomes of detainees are being managed appropriately?

Mr Douglas: If we go back to evidence we provided at the October Senate estimates hearing it indicated the stark reduction in the incidences of attempted natural self-harm in the detention network over the course of the preceding 12 months. We believe that, yes, as time progresses we are providing much better health care. I do not think any health system is ever going to be completely perfect—

Senator DI NATALE: Oh, please! Are you saying the Royal Australian and New Zealand College of Psychiatrists, the Royal Australian College of General Practitioners, the independent group of health experts, the Australian Psychological Society, the Royal Australian College of Physicians, the Australian Medical Association, the Asylum Seeker Resource Centre, the Hotham Mission Asylum Seeker Project, Amnesty International, the Australian Human Rights Commission, the Castan Centre for Human Rights Law and the Refugee and Immigration Legal Centre—all of whom have provided evidence that the current system is inadequate and is dealing inappropriately with the needs of detainees, and who have made submissions to support this bill—are all wrong?

Mr Douglas: I am not making any assessment of anybody else's submission. I am here to answer questions about the actions of the department in providing health care in a detention environment and the arrangements to support offshore processing.

Senator DI NATALE: I am asking you a question. They have all made submissions to say, 'We have made recommendation after recommendation that has gone nowhere, that people in these facilities are not getting access to appropriate health care,' and that something—

Mr Douglas: I do not believe that to be the case.

Senator DI NATALE: I have not finished my question—that something needs to be done to fix it. Are you saying that they are wrong in that assessment?

Mr Douglas: I am not making any assessment at all of anybody else's submission.

Senator DI NATALE: But I am asking you that question.

Mr Douglas: I am here to answer questions about the submission provided by the department and the action being taken by the department. The assertion you have made is that the department does not respond positively to any recommendations about healthcare treatment—

Senator DI NATALE: That is not the assertion I have made—

Mr Douglas: I do not believe that is the case. I believe the department has worked very constructively with its health care advisory arrangements over the course of the last six years. If it had not, I do not believe the people on those advisory groups would continue coming to those meetings and proffering their advice. I put before you the fact the psychological support program that is in use extensively, and has been very successful, is a policy that was substantially developed by the Detention Health Advisory Group, providing a significant value. So I do believe that proper health care is being provided across Australia's detention network, I believe that proper health care is being provided across Australia's detention network, and I believe that proper health care is being provided to people in regional processing centres.

Senator DI NATALE: Firstly, I did not make any such claim that all recommendations were ignored. I said 'many'. So let's be clear about that. Secondly, I do not think that evidence of somebody continuing to appear and present themselves through these fora, and in front of the department, is evidence that they are satisfied. In fact, it may be evidence of the complete opposite that they want to change what they see as a broken system. So I do not think that supports your contention. Let's just go on to a few of the other issues. Who will provide oversight to IHAG? What sort of process is there to—

Mr Douglas: It is an independent advisory group comprising nominated representatives of professional clinical associations. I know from my experience that such people bring along a very significant degree of independence in representing their organisations.

Senator DI NATALE: But they are working to implement the healthcare arrangements in those sittings, aren't they?

Mr Douglas: They are working to give advice to the department on systemic issues to do with health care across the immigration environment. They are not clinical service providers.

Senator DI NATALE: Should that advice be disputed, or should in fact the department not heed that advice, what sort of oversight mechanism exists at the moment?

Mr Douglas: Members of the Detention Health Advisory Group, where they have felt that—

Senator DI NATALE: I thought they had been decommissioned.

Mr Douglas: I am trying to answer your question, if I may, Senator. Where members of the Detention Health Advisory Group, throughout the period of its existence, felt that the government was not acting on its recommendation they have indeed spoken up and said so. The chair of the Detention Health Advisory Group has appeared in a number of public fora commenting quite freely on actions it believes that the government should do but has not done. So that seems to me to be a very independent approach.

Senator DI NATALE: So what you have just described is that if the recommendations are ignored DeHAG can essentially say publicly, 'We think these recommendations are being ignored,' and that is a satisfactory approach?

Mr Douglas: That is not at all what I am saying. I think you are twisting my words, with respect. What I am saying is that by and large the department works very closely with its advisory arrangements. I do not think anybody has presented any evidence to suggest that none of its recommendations have been implemented. What you are indicating is that some of those recommendations may not have been implemented or may not have been implemented to the satisfaction of the advisory group. What you are asking me about is the oversight arrangements that apply, and I am indicating to you that the independence of those members is such that, where they feel the department or the government has ignored its advice, they have not felt obstructed in being able to comment on that. So it is quite visible where there may have been disagreement. But I also pointed out to you that I would say a hallmark of success of the former Detention Health Advisory Group was the introduction of what we now have in place, which is a very effective psychological support policy.

Senator DI NATALE: Okay, we seem to disagree about whether an advisory group that feels it needs to speak out publicly is an appropriate accountability mechanism, but, that aside, you are saying that that is the accountability mechanism that exits at the moment, but we have just heard they have been decommissioned, and that was some time ago.

Mr Douglas: No, what we are doing is trying to move to a new stage of advice in relation to immigration health, building on the good work—

Senator DI NATALE: And where is that coming from? Where is that oversight coming from?

Mr Douglas: Building on the good work that has been done by DeHAG, which has been in operation for six years, the incoming secretary has said, 'I would like to build on that and create a group that looks more broadly across the immigration spectrum, not just in the detention environment, and looks at it not solely from a clinical

perspective but also from a broader health policy and systems perspective.' That is what he is working to do in establishing the new IHAG. The responsible organisations and professional associations have been written to asking them to nominate their members. They have until the end of this week to respond. Some of them have contacted us seeking an extension and more time to consider that. We expect that the new group will have its first meeting in the new year.

CHAIR: Are you saying that this new group—it has gone from DeHAG to IHAG—

Mr Douglas: Correct—

CHAIR: will actually look at health issues across the immigration perspective. So they could look at students and student visas?

Mr Douglas: They could.

CHAIR: Or the health and wellbeing of 457s, for example.

Mr Douglas: They could.

CHAIR: Who, independently and specifically, is going to reassure this nation that the contact you have in place with IHMS in detention centres, onshore and offshore, is working effectively? Who will concentrate on that?

Mr Douglas: I make the point that all of the contracts across all of the service provisions that exist in the Commonwealth are open to scrutiny across a whole range of different scrutiny measures, whether it be Senate committees or other parliamentary committees. We had for example the very extensive Joint Select Committee on Australia's Immigration Detention Network—

CHAIR: Yes, and you were going to get back to me on which of those—

Mr Douglas: There is scrutiny by the Australian National Audit Office, there is scrutiny by Commonwealth Ombudsman, there is scrutiny by the Australian Human Rights Commission—

CHAIR: I understand all of that, that is true—

Mr Douglas: There is scrutiny by the ministerial process—

CHAIR: What I asked you is who specifically is going to look at the health contracts and the health outcomes and wellbeing of people in detention onshore and offshore?

Mr Douglas: There is a range of scrutiny bodies that will be looking at the healthcare provision to people in regional processing centres—

CHAIR: Specifically name those for us.

Mr Douglas: We have outlined those for you. They are the Immigration Health Advisory Group, the Joint Advisory—

CHAIR: So the Immigration Health Advisory Group will be given the right, authority and power to travel to Nauru and PNG?

Mr Douglas: The Immigration Health Advisory Group has not met yet, and I would not want to speak on its behalf until it has the opportunity to meet. But if the Immigration—

CHAIR: But are there plans that it will do that?

Mr Douglas: If I may finish my answer, please, Senator. If the Immigration Health Advisory Group went to the secretary and said that it wants to undertake a visit, then we would look to do what could be done to support that, but it is not ultimately our decision; it is a decision also of the Nauruan government. I would make the point that good faith has already be shown in this regard. Over the course of the last three weeks both the Australian Red Cross and Amnesty International have visited the centre and had full and open access to the centre with the cooperation of the department and the Nauruan government. So I do not think we are trying to hide anything here.

CHAIR: We are not suggesting that, and I think you have missed the point there. What we are tyring to do here in relation to this bill is drill down only into the health, medical and mental wellbeing of people in detention centres onshore and offshore. So, you may well say to us that IHAG have yet to meet and if they request it we will try to facilitate it. I am asking you: does DeHAG not expect that they will regularly, proactively facilitate IHAG going to Nauru and PNG?

Mr Douglas: I expect that, in the same way that the department regularly facilitated frequent visits of members of the Detention Health Advisory Group to all of its onshore detention network centres, the same request would be put to the department, and facilitated, by the Immigration Health Advisory Group: that it would

seek to make contact with all of the onshore detention centres, and I imagine it would seek to visit the offshore regional processing centres as well.

Ms Parker: If I can also add that there are arrangements both in place and being established for the joint advisory committee—certainly the interim one—to make visits to the centres.

CHAIR: Seeing that you have added that, my next question is: in negotiating whatever the arrangements or the terms of reference will be with Nauru and PNG, will there be specific clauses in those agreements that allow for any independent oversight of the health arrangements?

Ms Parker: The oversight is meant to be by the joint advisory committee—

CHAIR: Correct.

Ms Parker: which will have members of, say, the Nauruan and the Australian government, members of the interim committee, MCASD—the minister's council that advises the minister—and we are also looking at some independent members from NGOs as well.

CHAIR: But what will the actual content of the agreement have in it that will drive the work of those members? Will it have specific clauses and content that go to the oversight of the mental and medical health of people in those countries under those conditions?

Ms Parker: It is at a reasonably high level in terms of establishing the committee for the purpose of providing that oversight and advice.

CHAIR: So once that agreement has been signed, sovereignty and jurisdictional access should not be a problem? If the agreement is satisfactory—watertight—and agreeable to both countries, then getting independent oversight of what is happening should not be a problem; is that right?

Ms Parker: Certainly, in relation to the advisory committees, which it has been agreed should be established.

Mr Douglas: I would also make the point that the Detention Health Advisory Group had a very active subcommittee which was dedicated to mental health. It also had regular access to the detention network, supported by the department. For the reasons that the committee has outlined this morning I fully expect that the incoming immigration health advisory group will have a very active subcommittee looking at mental health matters. It will also continue to get access to the detention centre network.

Senator DI NATALE: There is one thing that I am still not clear about. We have the independent health advisory group, which, you are saying, will provide the oversight that is necessary. In your submission you criticise the independent health panel that is being proposed, partly on the grounds that we may not get access to Nauru and PNG, being sovereign nations, and yet IHAG does not yet have access to either of those countries? What makes them different?

Mr Douglas: You have described it as a criticism. We were trying to point out that this was an issue that we thought would need to be considered by the committee.

Senator DI NATALE: But you have used IHAG as evidence of what will be effective in addressing the problem we all care about. Surely, it faces exactly the same problem that this independent health panel does. Yet you do not seem to think it is a problem, because you have described it as a tool that will be used to address the issue that we are worried about.

Mr Douglas: We were also saying that if you look at the joint advisory arrangements that Ms Parker has described, together with the immigration health advisory group arrangements, together with the extensive scrutiny of a range of other bodies, you will see that there would be quite a lot of scrutiny occurring.

Senator DI NATALE: That is not my point. My point is that you are saying this bill says that we are going to send an independent health panel over there. But that is a big problem, because we cannot just send this health panel over to Nauru and PNG. Then you say: 'We have this independent health advisory group over here. They can do the job; don't worry about that.' Why doesn't that face the same problem?

Mr Douglas: It will.

Senator DI NATALE: So why is that not a concern in this area but it is a concern for the proposed independent health panel?

Mr Douglas: We were posing that as an issue for the committee to consider.

Senator DI NATALE: But do you see my point? You are advocating for the independent health advisory group to be the oversight mechanism—it does not have access to Nauru or PNG, yet you are advocating for it—yet in your submission you use that as a point to indicate that this is a problem with the bill.

Mr Douglas: I think we have indicated that as being one of a number of issues for the committee to consider. I do not think we have outlined it as being the sole issue of determination.

Senator DI NATALE: No, but you have indicated it could be a problem.

Mr Douglas: No, I see it as an issue that would need to be considered.

Senator DI NATALE: An issue, a problem, a challenge—we can use whatever words we like, but I think we all agree that you have identified that as a specific issue that needs to be dealt with. Do you disagree with President Gillian Triggs, the new president of the Human Rights Commission in that this is not an issue at all and, in terms of our international law obligations, we have a responsibility for all actions over which we have control in other countries?

Ms Parker: In relation to what Ms Triggs said about Australia's international law obligations, that was her view or understanding. I think you will find that the Commonwealth government takes a different view.

Senator DI NATALE: We can send in bulldozers, earthmoving equipment. We can construct these facilities. We can send in a whole variety of contractors and other personnel, independent groups, and yet we cannot send a few health professionals over. That is a huge problem in terms of getting access to those countries.

Mr Douglas: Sorry, what is the question?

Senator DI NATALE: I am asking: why is this such a big difference between what we have done there already? What we are proposing to do with other bodies and with the proposed independent panel?

Ms Parker: I think what we were trying to say in this submission is merely that we cannot just have the Australian parliament deciding that it will impose a panel on Nauru and or PNG or any other country and that would be subject to their agreement.

Senator DI NATALE: So you then have the same concerns about the international health advisory group, I take it.

Ms Parker: I think Mr Douglas already indicated that that would have to be subject to Nauru and Manus agreement as well.

Senator DI NATALE: But Mr Douglas identified it as one of the bodies that would be responsible for oversight.

Ms Parker: Subject to the agreement of the regional processing country. In relation to the oversight that has been agreed or is in the process of being agreed, it is the joint advisory committees that are being set up.

Senator DI NATALE: Do you have concerns that all of the offshore centres will be at capacity? Do you have concerns about the fact that the problem may get worse?

Mr Douglas: Which problem would that be?

Senator DI NATALE: There is the problem of 14 people living in a tent, having complications from the environment that they live in— skin conditions and so on—and obviously now the concerns around people who are on hunger strikes and so on. Are those a concern for, given the numbers?

Mr Douglas: As my evidence earlier this morning indicated, we are moving to put in place the permanent accommodation structures as quickly as we can. We believe the first of those buildings will be ready for assembly by the middle of next month and occupation shortly thereafter. They progressively will come on stream.

Senator DI NATALE: Dr Choong-Siew Yong from the Australian Medical Association said that he believed it was critical to have input at the design stage of the centres to ensure that health is recognised as a key priority in the design of these centres. In fact, he cited Villawood as an example of where that was not the case. We are now at the stage where we are designing and building new centres. What sort of consideration is being given to designing the centres to ensure that health is one of the key priorities in the design stage?

Mr Douglas: We have used a design approach that is consistent with the way that we have designed many of the facilities that are in operation across the onshore network, including over the course of the last few years at Yongah Hill near Northam, Scherger in North Queensland and Curtin in northern Western Australia. We have applied much of the same design principles there. These are primarily around ensuring opportunities for people to undertake programs and activities, to have access to gymnasiums, for example, and to have access to open space to conduct sports activities. In addition in relation to the offshore centres, you would have seen in the press over the course of the last few days that the Nauruan foreign minister has indicated that he expects the Nauruan parliament next week will allow for daylight hours egress from the processing centre for people there to have more free movement around the island. So we have basically taken a fairly broad approach.

Senator DI NATALE: My question was much more specific than that. We have recognised that there are serious health consequences of being in detention. We have had evidence presented today that there needs to be input from the health and medical profession into the design of these facilities. I am asking a very specific question: what input has there been from health professionals into the design of these centres, and can you outline the nature of that input?

Mr Douglas: There has not been specific health professional advice in relation to the design of the processing centre at Nauru.

Senator DI NATALE: Do you think that would be a valuable addition to the design of the centres?

Mr Douglas: We will consult with a range of our contracted service providers who are responsible for the provision of operations at those centres, and they will give us advice about the extent to which the design meets their operational requirements. In the course of getting that advice we will take advice from all of those contracted providers, including the Salvation Army and IHMS, in relation to the adequacy of the design for people to meet the broader health-care needs.

Senator DI NATALE: Let us say that IHAG is established, that a number of recommendations are made and that some key recommendations are ignored. What is the process for resolving that?

Mr Douglas: I am not too sure that I completely accept your proposition, so I find it difficult to answer. In the event that a recommendation from any advisory committee or any scrutiny body was ignored, I would expect that there would be full and open disclosure of that. For example, there is quite extensive scrutiny by the full range of bodies that I outlined earlier, and the members of the advisory group have not felt bound not to say anything where they believe a recommendation has not been acted upon and where they have been vocal about that. I would expect that the same process would continue. It was always open for the parliament to undertake further scrutiny where it believed that a particular action should have occurred that did not. The estimates committee process runs on three separate occasions through the year, and we respond to numerous questions in each session about the extent to which we have or have not done particular things. I would expect that the same, extensive level of scrutiny and accountability would continue.

CHAIR: I think Senator Boyce was keen to know about a few issues around children or people with disabilities, and I am going to ask you these two questions which you can either answer now or take on notice. Who on the to-be-established IHAG has specific expertise in people with disabilities?

Mr Douglas: The members of IHAG have not yet been nominated by the respective associations, so I cannot answer that yet.

CHAIR: Do any of the associations from whom you have sought a nomination have specific expertise in people with disabilities?

Mr Douglas: I would have to take that on notice.

CHAIR: All right. In the construction of the camps at Nauru and PNG, has consideration being given to the needs of people with disabilities?

Mr Douglas: We are proceeding as if the buildings would need to be compliant with the Building Code of Australia, and that would require that services be effective for people with disability.

Ms Parker: I add that, before people are taken to a regional processing centre, they undergo a pre-transfer assessment which would include looking at their medical appraisal beforehand in terms of what disabilities and vulnerabilities they may have. Part of that pre-transfer assessment also looks at whether the conditions and the services available in the regional processing country would be suitable such that they would be able to be taken to the regional processing country.

Senator PRATT: For the sake of clarity, the report of the Expert Panel refers to the monitoring, care and protection arrangements by a representative group from government and civil society in Australia and Nauru. I want to be clear if that is IHAG or the other body that you were referring to, or neither.

Ms Parker: It is the joint advisory or oversight committee. At the moment, as I mentioned, we are establishing an interim committee which will run for six months pending setting up two separate committees, one for each regional processing country.

Senator PRATT: Okay. Is it envisaged that those bodies have a monitoring role or an oversight and implementation function?

Ms Parker: It is both, with the capacity then to advise the respective governments on issues that may come to the fore.

Senator PRATT: So does that mean that that group will be separately mandated to monitor and critique contracts and whether those have been adequately implemented or not?

Ms Parker: It is in relation to the establishment and operation of the centres. I believe so. It is not only health but also things like looking at the arrangements for processing the claims of people who are transferred to the centres—it is the whole range.

Senator PRATT: I am a little unclear about the distinction between monitoring and implementation and whether combining the two is in effect the most appropriate way to proceed. I note, for example, that in many custodial settings—and I appreciate we are not talking about a custodial setting here—in which people's movement is restricted and they do not have control over what services they access or where they are, very independent monitoring systems are becoming more recognised as being important. I have not seen much evidence as to whether the Department of Immigration and Citizenship—and this might be a policy question separate to implementation—has given consideration to what arrangements are ideal for the circumstances that we are dealing with here.

Ms Parker: The government has accepted in principle the recommendations of the Expert Panel and you have pointed out the language that was used in the Expert Panel report. That is meant to be reflected in this joint advisory or oversight committee that that would be the body that is reporting and looking at all the various aspects of the regional processing arrangements.

Senator PRATT: I suppose in that sense it is a reflection of whether the Expert Panel has adequately dealt with whether such oversight is independent or not. I suppose that is a bigger question. Thank you.

CHAIR: I thank both of you for your time and your assistance this afternoon. We would need the answers to our questions by close of business on Tuesday so that we can put more answers in our report, if we need to do that. We report on 7 December.

Committee adjourned at 12:58