

Responding to mandatory immigration detention: Lessons for the healthcare community

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Intro-line: After twenty five years of advocacy, what can the healthcare community learn from recent reforms of Australian immigration detention?

Abstract: Now that children have been removed from offshore immigration detention centres and with the Migration Amendment (Urgent Medical Treatment) Bill (2018) being passed into legislation, what can the healthcare community learn after over two decades of advocacy? Below we offer some reflections on the progress that has been made, including the medical community's contribution to the reform of these policies and what we can learn for future action.

The Australian government recently announced that they had removed all refugee and asylum seeker children from offshore detention on Nauru (1). Even more recently, Australian parliament passed the Migration Amendment (Urgent Medical Treatment) Bill (2018) (2). This legislation strengthens doctors' position to recommend a transfer of an ill person to Australia for treatment from offshore detention centres on Manus Island (Papua New Guinea) and Nauru. While this has been welcome news, these developments are tempered by the fact that the government has resisted these changes and even attempted to politicise these issues, e.g. re-opening the Christmas Island detention centre while claiming the Bill would weaken Australia's borders (3).

Immigration detention has been one of the most contentious contemporary political issues in Australia for over a quarter of a century. Onshore detention was introduced in 1992. Offshore processing on Manus Island (Papua New Guinea) and Nauru was introduced in 2001 with bipartisan political support. Offshore detention ceased in 2007 but was reinstated in 2012, again with bipartisan support (4). These policies have resulted in the detention of tens of thousands of men, women and children both onshore and offshore. Conditions within detention centres have been unsafe and violent. Multiple inquiries have provided details on widespread physical

and sexual abuse, violence, riots, self-harm and suicidal behaviour (3). Despite these facts, however, and despite widespread criticism, the Australian government has persevered with offshore processing, explicitly as a deterrent to further asylum seeker boat arrivals (5). The harm created and perpetuated by these policies is deliberate, and arguably fulfils the United Nations definition of torture (6).

The Australian healthcare community has been closely involved with these policies, calling for their reform and working within detention centres to provide healthcare. While there have been a number of more cooperative efforts made to improve the delivery of healthcare, such as the formation of the immigration health advisory group (IHAG), these have more generally been resisted, short-lived or disbanded as was the case with IHAG (7). More generally the Australian government's relationship with the healthcare community could best be described as antagonistic, with the government resisting calls for broader systemic reform. This has led many to pursue unconventional action, outside of their more traditional clinical roles. Clinicians have played a central role in bringing to light the conditions in which people are detained in testimony to inquiries and whistleblowing (8). Professional bodies have long called for reform (9). Clinicians have lobbied, marched and protested against these policies (10, 11). Prior to the evacuation of children from Nauru, almost 6000 Australian doctors signed an open letter calling for the evacuation of all children from detention there (12). Action has also been more adversarial. After the introduction of the Border Force Act (13) many saw civil disobedience as their only option, publicly challenging the government to prosecute while continuing to speak out (14). Clinicians have also defied the government in refusing to discharge children from hospital if returned to Nauru (15). Others have taken action to address the well documented failings of healthcare offshore by reviewing medical records and advocating for treatment. In many cases clinicians have acted in partnership with the media to amplify their message.

As a whole and over a number of years, this action has had a substantial impact on broader protest and in shaping public discourse. While it is difficult to pinpoint its precise contribution to recent shifts in policy, it is no understatement to say that the healthcare community has played an influential role in this debate. We cannot assume however we are at the end of the road or that this recent progress will be maintained. While this article was being written, the

Nauruan government passed legislation threatening the Migration Amendment (Urgent Medical Treatment) Bill (2018) (2), banning medical transfers based on telehealth assessments (16). Many also remain in detention both offshore and onshore. It is worth reflecting on how we have reached this point. If we are to take some lessons from progress thus far, what should they be?

1. Research

If we can do nothing else, we should continue to speak of the harms of these policies; research provides a powerful platform on which this can be done. There is an existing body of evidence that has detailed the harms of detention (3, 17, 18) and also outlined the ethical and practical issues faced in the delivery of healthcare (19, 20). There are other opportunities for further investigation, particularly when exploring how the healthcare community should respond to these policies. Beyond clinical ethics, research and reflection is needed on how the healthcare community should position itself in the face of power and politics. There is fortunately a growing literature that can be learnt from here (21). In addition to this, research will also be particularly important in any future legal proceedings, providing evidence of the harm these policies have created and perpetuated.

2. Working with lawyers

Partnerships with lawyers and other legal professionals have proven to be particularly important. Prior to the Migration Amendment (Urgent Medical Treatment) Bill (2018) (2) coming into force and children being removed from Nauru, every child who was transferred to Australia for treatment was done so by court order (22). Ongoing collaboration for future legal action, advocacy and research should be nurtured. This will require cooperation, dialogue and a mutual respect of the expertise of each profession.

3. Working with the media

The media has also played an important role in uncovering the secrecy the government has tried to place around detention centres and conditions on Nauru and Manus Island. Much of what we know today about immigration detention has come from clinicians speaking out about

their experiences working in detention centres. Others have turned to the media to highlight specific cases of substandard care. While care is needed in obtaining consent, there are a number of examples of how the media has been effectively utilised to prompt the government to take action (23).

4. Advocacy and systemic reform

We should continue to advocate for our patients, but more importantly, for systemic reform (24) in line with the international human rights commitments the Australian government has made. While advocacy within the constraints of detention is necessary and may result in small immediate gains, human rights will continue to be violated and health suffer as a result. Arguably the biggest achievements in relation to the health and wellbeing of those detained offshore; evacuating children from detention and the Migration Amendment (Urgent Medical Treatment) Bill (2018) (2), have not come about through care as usual, but through years of political pressure and advocacy.

5. Civil disobedience and activism

How we advocate for systemic reform however is often not straightforward. The Australian government's response to evidence and criticism has created a unique challenge for the healthcare community. The things we have been trained to do, that is advocate and act on evidence, have been rendered largely ineffective (25). This has led many to take increasingly adversarial action such as whistleblowing, protest and civil disobedience. There is substantial scholarship in this area which highlights the effectiveness of non-violent direct action (21, 26); we shouldn't shy away from it given the circumstances.

Beyond those discussed above, a number of other lessons could be taken away from the healthcare communities' response to mandatory immigration detention, these are impossible to list and in many ways, a list may not do them justice. Thus equally important is the broader conversation related to the role of the healthcare community in social and political change. There will be disagreement, not just with our points above, but more generally: how can we be most effective in pursuing social and political change? What forms of action might be

acceptable in this pursuit? Should we simply stick to clinical work? We can learn from policies, like mandatory immigration detention, we can also learn from history to help answer these questions. One point is clear however, this will not be the last time the healthcare community will find itself advocating for a marginalised group of people, it is also unfortunately not the last time we will be faced with the question of what to do in response to major human rights abuses.

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