

POLICY PAPER

HEALTHCARE AND THE HEALTH-RELATED HARMS OF AUSTRALIA'S REFUGEE EXTERNALISATION POLICIES

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1. Introduction

1.1 Overview of CONREP and the Externalisation of Refugee Protection

This policy paper examines the health-related harms of Australia's refugee externalisation policies, focusing on the harms arising from the provision or denial of healthcare to refugees and asylum seekers under Australia's extraterritorial asylum regime. Externalisation policies comprise the central focus of the Comparative Network on the Externalisation of Refugee Policies (CONREP). CONREP researches the impact and effects of the externalisation of refugee policies in two regions: Australia's activities in Southeast Asia and the Pacific; and the European Union and its member states' activities in North Africa. These policies exploit power asymmetries to transfer state and regional obligations and responsibility for asylum seekers and refugees to neighbouring states. At their most destructive, externalisation policies can prevent refugees from reaching safety, and breach their human rights.

As has been extensively demonstrated, externalisation policies reshape the boundaries of sovereignty and blur the lines of responsibility among states. By seeking to avoid their legal and political responsibility, many states violate their legal obligations. Externalisation seeks to deflect responsibility, transforming the governance of refugee protection and border control. Regional cooperation for refugee protection is weakened, and human rights protections are undermined. At a global level, migration pathways are disrupted and refugees are often trapped in transit, placing them at risk. Nationally, some governments position themselves as being "tough" on border protection in order to seek to gain electoral advantage. The accelerating phenomenon of externalisation characterising these "tough" border protection policies requires a comprehensive analysis by researchers, civil society actors, refugees and policy makers.

This policy paper details Australia's extraterritorial asylum regime in Papua New Guinea (PNG) and Nauru alongside its immigration detention regime in Australia, in order to show the health-related impacts of refugee externalisation on the health of those seeking asylum. The re-introduction of Australia's so-called "offshore" detention and processing

regime in 2012 caused a "looming humanitarian emergency" and an unprecedented mental health crisis among refugees and asylum seekers in PNG and Nauru.¹ While many people have since been transferred to Australia for medical reasons or resettled in the USA, refugees who remain in PNG and Nauru as well as refugees who are now in Australia, continue to have drastically inadequate access to healthcare while enduring legal limbo, precarity and insecurity.

1.2 A Universal Right to Decent Healthcare

Regardless of legal status, all persons have the right to decent health and medical care under international law and to enjoy their right to health.² The UN Special Rapporteur on the Right to Health has stated that:

The right to the highest attainable standard of health is to be enjoyed without discrimination. It is especially important for vulnerable persons, such as asylum-seekers and persons in detention.³

The Australian government has also recognised the importance of the right to health:

The right to health is the right to the enjoyment of the highest attainable standard of physical and mental health. The UN Committee on Economic Social and Cultural Rights has stated that health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.⁴

In its most recent report, Australia's Commonwealth Ombudsman contains extensive recommendations that affirm the right to health in immigration detention, including mental health, and the right to adequate protections against the spread of COVID-19.⁵ It contained several recommendations relating to "the need for people in detention to access a commensurate level of programs, activities and health support, as people held in facilities on the mainland".⁶

Alongside this legal context, ensuring access to decent healthcare is also a matter of justice and equal treatment of all human beings. Refugees and asylum seekers themselves

1 United Nations High Commissioner for Refugees (UNHCR), "UNHCR Statement: Australia Must Prevent Looming Humanitarian Emergency in Papua New Guinea", October 18, 2017, <https://www.unhcr.org/en-au/news/press/2017/10/59e8a0384/unhcr-statement-australia-must-prevent-looming-humanitarian-emergency-papua.html>.

2 *Universal Declaration of Human Rights* (1948), article 13; *International Covenant on Economic, Social and Cultural Rights*, 993 UNTS 3 (1976), article 12; *Convention on the Elimination of All Forms of Racial Discrimination*, 660 UNTS 195 (1969), article 5; *Convention on the Elimination of All Forms of Discrimination against Women*, 1249 UNTS 1 (1981), articles 10(h), 11(1)(f), 12, 14(2)(b), 16(1)(e); *Convention on the Rights of the Child*, 1577 UNTS 3 (1989), articles 24, 25; *Convention on the Rights of Persons with Disabilities*, 2515 UNTS 3 (2008), articles 23 (1)(c), 25.

3 *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover: Mission to Australia*, UN Doc A/HRC/14/20/Add.4 (June 3, 2010) 15.

4 Australian Government, Attorney General's Department, "The Right to Health (Guidance Sheet)", n.d., <https://www.ag.gov.au/rights-and-protections/human-rights-and-anti-discrimination/human-rights-scrutiny/public-sector-guidance-sheets/right-health>.

5 Commonwealth Ombudsman, *Monitoring Immigration Detention: The Ombudsman's Oversight of Immigration Detention* (2022), https://www.ombudsman.gov.au/__data/assets/pdf_file/0012/115005/Monitoring-immigration-detention-report-July-2020-to-June-2021.pdf.

6 *Ibid* 2.

have drawn attention to the importance of access to decent healthcare, asserting that the provision of proper healthcare can only occur in non-punitive and non-carceral settings.

1.3 Asylum and the Medical Border

This policy paper deploys the concept of “the medical border” in order to examine how “medical personnel, practices, knowledges and logics have become enmeshed in the performance, function and ends of state border regimes”.⁷ Through this concept, we illuminate how border regimes use healthcare – or rather, the denial of, and limited access to healthcare – as a tool to control and harm individual migrants and their bodies. The concept of the medical border also helps to show how “healthcare has become a form of border control in Australia’s contemporary border regime”, including in relation to Australia’s extraterritorial asylum regime.⁸ The effect is that medical systems within border regimes are central to enacting a politics of inclusion and exclusion and inform how states seek to control particular forms of movement at the border.⁹

This policy report finds that Australia’s denial of proper healthcare to refugees has become a form of border violence, which is enabled as an effect of the externalisation of refugee protection. The report also finds however that the politics of healthcare provision can facilitate forms of resistance and agency enacted by those seeking refuge.

1.4 Settler Colonialism and the Racial Politics of Exclusion

The violence of Australia’s refugee externalisation practices has its roots in Australia’s colonial history and ongoing practices of settler colonialism. Australia’s colonial origins, including as a penal settlement for British convicts, initiated a history of violence against Indigenous peoples and the dispossession of their land by British settlers, as well as the use of military law and autocratic governance practices. The harmful effects of this history have been the subject of substantive record, testimony and analysis.¹⁰ Importantly,

as historian and theorist Patrick Wolfe observed, in settler colonialism, the settler “comes to stay”, with the (re) production of state sovereignty being a constant, ongoing project that relies on the “logic of elimination” vis-a-vis Indigenous sovereignty and Indigenous peoples: this is always a project of racialised domination that uses certain types of migrants to displace Indigenous peoples, and keeps out - and punishes - other migrants.¹¹

Structural injustices and Australia’s penal history continue in the present for Indigenous peoples in the form of high rates of Indigenous incarceration, deaths in custody, and the ongoing removal of Indigenous children from their families.¹² Australia, then, is a place with deep historical foundations in penalty, coercion and racialisation which manifest in contemporary laws, policies and practices, including through the use of immigration detention and “offshore” processing.

Mandatory immigration detention draws on this history of strong institutional control over migration, reproducing the exceptional, military provisions invoked by settler colonies seeking to exert control over – and to mete out punishment to – Indigenous peoples. For example, under policies of mandatory immigration detention and “offshore” processing, refugees have been forcibly expelled from Australia, quarantined in penal settings and denied access to legal protections in a manner which continues early settler history in Australia. Immigration detention, as *administrative detention*, is thus connected with this country’s use of missions, quarantine stations, enemy internment camps and prisons as central mechanisms for the management of populations.¹³ As Nethery remarks:

In Australia, administrative detention was fundamental to the establishment of the settler colonial nation. Thereafter, this form of incarceration became a template, imbued with the racial and cultural whiteness of settler colonial societies, to which future policymakers have reached time after time to manage perceived threats to national identity, integrity, or security.¹⁴

Immigration detention thus embodies strategies of regulation, incarceration and surveillance characteristic of penal institutions that also have distinctly medical effects

7 Sara Dehm, “The Entrenchment of the Medical Border in Pandemic Times.” *Border Criminologies* (blog), July 15, 2020, <https://www.law.ox.ac.uk/research-subject-groups/centre-criminology/centreborder-criminologies/blog/2020/07/entrenchment>.

8 Ibid.

9 To date, the concept of the “medical border” has been theorised by historians and social anthropologists: see, for example, Alison Bashford, *Medicine at the Border: Disease, Globalization and Security, 1850 to the Present* (Palgrave Macmillan, 2006); John Mckiernan-González, *Fevered Measures: Public Health and Race at the Texas-Mexico Border, 1848–1942* (Duke University Press, 2012).

10 Aileen Moreton-Robinson ed., *Sovereign Selves: Indigenous Sovereignty Matters* (Allen and Unwin, 2007); Marilyn Lake and Henry Reynolds, *Drawing the Global Colour Line: White Men’s Countries and the Question of Racial Equality* (Melbourne University Press, 2008); Julie Evans, “Where Lawlessness is Law,” *Australian Feminist Law Journal* 30 (2009): 3–22.

11 Patrick Wolfe, *Settler Colonialism and the Transformation of Anthropology: The Politics and Poetics of an Ethnographic Event* (Cassell, 1999).

12 Harry Blagg, “Colonial Critique and Critical Criminology: Issues in Aboriginal Law and Aboriginal Violence.” In *The Critical Criminology Companion*, edited by Thalia Anthony and Chris Cunneen (Hawkins Press, 2008): 129–143; Larissa Behrendt and Nicole Watson, “Shifting Ground: Why Land Rights and Native Title Have Not Delivered Social Justice.” *Journal of Indigenous Policy* 8 (2007): 94–102.

13 Alison Bashford and Carolyn Strange, “Asylum-Seekers and National Histories of Detention,” *Australian Journal of Politics & History* 48, no. 4 (2002): 509–27; Amy Nethery, “Incarceration, Classification and Control: Administrative Detention in Settler Colonial Australia,” *Political Geography* 89 (2021).

14 Nethery, “Incarceration, Classification and Control,” 8.

that manifest adversely upon those detained. In examining the harmful effects of immigration detention, this report is also a call for the dismantling of this system of border control and the laws enabling it, as a practice which is always a source and cause of harm. Such harm can never be addressed while this system remains in place: it can only be “managed”.

1.5 Immigration Detention as Fundamentally Harmful

Immigration detention is a form of state violence against refugees and asylum seekers.¹⁵ The harms endured by people who are subjected to Australia’s border policies are long-standing, systemically produced, and manifest in diverse medical conditions that are often endured long after release.¹⁶ The experience of being detained, including the physical setting, treatment by officers, the use of force, handcuffing, isolation cells and surveillance amount to breaches of the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (CAT).¹⁷ These are places of punishment: they look, feel, smell and operate like prison settings.¹⁸ They are intended to inflict suffering. Notably, detention has impacted particularly adversely on children, with effects ranging from difficulties in maintaining a “normal” routine to witnessing acts of extreme violence. Allegations of systemic sexual abuse of those in detention, including children, have continued to circulate with alarming regularity.¹⁹

This is especially troubling in the case of unaccompanied children, towards whom the Government has a legal obligation of care under the *Immigration (Guardianship of Children) Act 1946* (Cth).²⁰ Ten years after the first report was released by the Australian Human Rights Commission (AHRC) which detailed the effects of detention upon

children, the AHRC’s *The Forgotten Children* report repeated the same concerns.²¹ Extensive research has found that while in detention and following release, children have consistently displayed post-traumatic stress disorder, experienced high levels of anxiety and suicidal ideation.²²

For both adults and children, there is a direct correlation between the length of time someone is in detention and mental illness,²³ a correlation which remains “robust” even after accounting for other variables and is exacerbated by prior trauma,²⁴ and often manifesting in clinical depression, mutism and disengagement.

According to Monash University’s Australian Border Deaths Database, over 2,000 people have died either on route to Australia, in Australian-run immigration detention, or after release or deportation since 2010.²⁵ Records indicate that there have been 41 deaths while detained onshore, and 17 deaths while detained either in Nauru or PNG. Beyond this, there are numerous cases of persons who were released from detention yet died as a result of untreated or poorly treated medical conditions, or from suicide. This shows that relief from medical and other harms do not end with a person’s release into community.²⁶ Many report ongoing mental illness, dental problems and other pathological conditions such as chronic skin conditions or poor heart conditions. As noted in 2020, in a study conducted by Kylie Hedrik et al, the authors observed that:

It is now well established that immigration detention has a deleterious impact on the psychological well-being of many asylum seekers, and that these adverse effects may be enduring.²⁷

These harms are the direct impact of Australia’s system of mandatory immigration detention, including laws and policies that allow for prolonged, indefinite incarceration.

- 15 Michael Grewcock, “Australian border policing, the detention of children and state crime”, in *The Routledge International Handbook of Criminology and Human Rights*, ed. Leanne Weber, Elaine Fishwick and Marinella Marmo. Routledge, (2016): 157 - 168.
- 16 Lisa Hartley and Caroline Fleay, “Released but Not Yet Free: Refugees and Asylum Seekers in the Community after Long-Term Detention.” (Curtin University Centre for Human Rights Education, December 2012); Kylie Hedrick et al., “Self-Harm among Asylum Seekers in Australian Onshore Immigration Detention: How Incidence Rates Vary by Held Detention Type,” *BMC Public Health* 20, no. 1 (2020): 592.
- 17 *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 1465 UNTS 85 (1987); Mary Anne Kenny and Lucy Fiske, “Regulation 5.35: Coerced Treatment of Detained Asylum Seekers on Hunger Strike: Legal, Ethical and Human Rights Implications,” in *The Ashgate Research Companion to Migration Law, Theory and Policy*, ed. Juss S Satvinder (Routledge, 2013); Madeline Gleeson et al., *Chapter 2: Immigration Detention, The Implementation of OPCAT in Australia* (The Australia OPCAT Network, January 2020).
- 18 Joseph Pugliese, “The Tutelary Architecture of Immigration Detention Prisons and the Spectacle of ‘Necessary Suffering,’” *Architectural Theory Review* 13, no. 2 (2008): 206–21; Poppy de Souza and Emma Russell, “Sensing the Border(s): Sound and Carceral Intimacies in and beyond Indefinite Detention,” *Crime, Media, Culture: An International Journal* (2022).
- 19 Human Rights and Equal Opportunity Commission, *A Last Resort? National Inquiry into Children in Immigration Detention* (April 2004), <https://humanrights.gov.au/our-work/asylum-seekers-and-refugees/publications/last-resort-national-inquiry-children-immigration>.
- 20 Jordana Silverstein, “‘I Am Responsible’: Histories of the Intersection of the Guardianship of Unaccompanied Child Refugees and the Australian Border.” *Cultural Studies Review* 22, no. 2 (2016): 65–89.
- 21 Australian Human Rights Commission, *The Forgotten Children: National Inquiry into Children in Immigration Detention* (2014), https://humanrights.gov.au/sites/default/files/document/publication/forgotten_children_2014.pdf.
- 22 Sarah Mares and Jon Jureidini, “Psychiatric Assessment of Children and Families in Immigration Detention – Clinical, Administrative and Ethical Issues,” *Australian and New Zealand Journal of Public Health* 28, no. 6 (2004): 520–26; Sarah Mares and Karen Zwi, “Sadness and Fear: The Experiences of Children and Families in Remote Australian Immigration Detention,” *Journal of Paediatrics and Child Health* 51, no. 7 (2015): 663–69; Zachary Steel et al., “Psychiatric Status of Asylum Seeker Families Held for a Prolonged Period in a Remote Detention Centre in Australia,” *Australia N Z J Public Health* 28, no. 6 (2004): 527–36; Australian Human Rights and Equal Opportunity Commission, *Report of an Inquiry into a Complaint by Mr Mohammed Badraie on Behalf of His Son Shayyan Regarding Acts or Practices of the Commonwealth of Australia* (2002).
- 23 Joint Select Committee on Migration, *Final Report on the Immigration Detention Network 2012* (Commonwealth of Australia, 2012).
- 24 Zachary Steel and Derrick M Silove, “The Mental Health Implications of Detaining Asylum Seekers,” *Medical Journal of Australia* 175, no. 11–12 (2001): 596–99; AHRC, *The Forgotten Children*.
- 25 Monash Migration and Inclusion Centre, *Australian Border Deaths Database* (Monash University, n.d.), <https://www.monash.edu/arts/migration-and-inclusion/research/research-themes/migration-border-policy/australian-border-deaths-database>.
- 26 Lisa Hartley and Caroline Fleay, “Released but Not Yet Free”.
- 27 Hedrick et al., “Self-Harm among Asylum Seekers in Australian Onshore Immigration Detention,” 2.

2. The Law and Policy of Australia's Refugee Externalisation

2.1. Australia's Immigration Detention Regime

"They did the pat search after checking the rooms, and all was trauma and sadness. Sickness. And when we went to the medical centre inside the detention it was IHMS. And they said 'you can go back to your country if you cannot continue. Have you thought about going back to your country?' They just prescribed Panadol and water... There was no proper medical care for the refugees. Everything was torture."

– Mostafa Azimitabar, *Kurdish refugee, Park Hotel survivor and human rights advocate*

Australian law requires the mandatory detention of all people deemed to be "unlawful non-citizens".²⁸ This mandatory detention specifically targets refugees and asylum seekers who have arrived by boat without state authorisation (that is, without a valid visa)²⁹

Australia's immigration detention regime consists of both community detention and closed detention.³⁰ Since 2001, Australia has also operated immigration detention facilities extraterritorially on PNG and Nauru. As outlined below, this has had two distinct phases of operation: 2001-2007; and 2012-ongoing. This policy paper focuses primarily on closed immigration detention, both within Australia and under the latter phase of Australia's extraterritorial detention regime in PNG and Nauru, both of which have involved the physical imprisonment of people in a secure, prison-like facility. Within Australia, these facilities are officially referred to as "immigration detention centres".³¹

As affirmed by the High Court of Australia,³² Australian law allows for a person to be held in immigration detention on an indefinite basis. Unlike other jurisdictions like the United Kingdom, Australia does not have a system of immigration bail that permits people to seek review of their detention. Instead, under Australian law, the power to release a person from immigration detention lies with the Minister

for Immigration either through the grant of a visa, making a residence determination or by effecting deportation. This is a statutory non-compellable, non-reviewable Ministerial power, meaning that the Minister has the near-absolute discretion to keep a person deemed to be an "unlawful non-citizen" in immigration detention as they see fit.

In recent years, much attention has focused on Australia's law and policy of Australia's extraterritorial asylum regime in PNG and Nauru. This policy of so-called "offshore" detention started in 2001 as a governmental response to the perceived threat of asylum seekers and refugees arriving by boat, labelled – not for the first time – as "illegals" and "queue jumpers".³³ Although this "offshoring" of refugees was suspended in 2007, since then there has been a gradual reinstatement of extraterritorial detention now framed through the "humanitarian" discourse of "saving lives at sea".³⁴ In August 2012, Australia's policy of "offshore" detention was reinstated with the opening of immigration prisons in Papua New Guinea and Nauru. In September 2013, this refugee externalisation strategy through extraterritorial detention was subsumed within Australia's broader policy of "Operation Sovereign Borders" that worked to further militarise Australia's national border. Australia has faced, and continues to face, both domestic and international criticism for the violence, trauma and harm that is integrated within and produced by this extraterritorial detention regime.

As at 28 February 2022, there were 1,554 people in immigration detention in Australia and people were detained for an average of 687 days.³⁵ Furthermore, 20.7% of people in detention had been detained for a period of between 731 and 1,825 days.³⁶ That is 128 people who have been detained for longer than 5 years. As of the end of May 2022 there were 112 people seeking protection still in Nauru and 105 people seeking protection in Papua New Guinea.³⁷ The length of time spent in detention well exceeds that of other immigrant-receiving countries and places Australia's immigration detention regime in stark contrast to practices of immigration detention internationally.³⁸ It is also well-recognised that lengthy and indefinite detention is detrimental to physical and mental health and constitutes an egregious breach of the obligations that Australia holds under the Refugees Convention.³⁹ Indeed, as detailed below,

28 *Migration Act 1958* (Cth), section 189.

29 *Migration Act 1958* (Cth), section 501. See Jane McAdam, "Australia and Asylum Seekers," *International Journal of Refugee Law* 25, no. 3 (2013): 435–48.

30 Public Interest Advocacy Centre, *In Poor Health: Health Care in Australian Immigration Detention* (2018), <https://piac.asn.au/wp-content/uploads/2018/06/18.06.14-Asylum-Seeker-Health-Rights-Report.pdf>.

31 *Ibid.*

32 See, eg, *Al-Kateb v Godwin* (2004) 219 CLR 562.

33 McAdam, "Australia and Asylum Seekers," 436.

34 Jordana Silverstein, "Refugee Children, Boats and Drownings: A History of an Australian 'Humanitarian' Discourse," *History Australia* 17 no. 4 (2020): 728–742.

35 Department of Home Affairs, "Immigration Detention and Community Statistics Summary," January 31, 2022, <https://www.homeaffairs.gov.au/research-and-stats/files/immigration-detention-statistics-28-february-2022.pdf>.

36 *Ibid.*

37 Refugee Council of Australia, "Offshore Processing Statistics," June 13, 2022, <https://www.refugeecouncil.org.au/operation-sovereign-borders-offshore-detention-statistics/2/>.

38 Public Interest Advocacy Centre, *In Poor Health*.

39 *Convention Relating to the Status of Refugees*, 189 UNTS 150 (1951); Saba Vasefi and Sara Dehm, "Refugee Women and the Gendered Violence of Australia's Extraterritorial Asylum Regime on Nauru," *Refugee Survey Quarterly* 41, no. 3 (2022).

any form of immigration detention at all on the basis of a person's legal status is unjust and can cause damage.

2.2. The Right to Health in International Law

"The reality is that we are all human beings and there shouldn't be any difference between human. And they are innocent like me. And they are still in detention. They haven't done anything wrong, it's just because of policy, this policy has decided to free a part of the refugees and locked up the others, because they wanted to show people that refugees are less than human beings; that refugees are bad people."

– Mostafa Azimitabar, Kurdish refugee, Park Hotel survivor and human rights advocate

International law recognises the right of refugees, asylum seekers and undocumented migrants to access decent essential healthcare. This recognition specifically arises from article 12 of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) that recognises "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".⁴⁰ The UN Committee on Economic, Social and Cultural Rights General Comment No 14 (2000) has interpreted the universal right to health under article 12 to mean that asylum seekers should not be denied "preventative, curative and palliative health services".⁴¹ Importantly, the Committee emphasised that states must not adopt health policies or practices that discriminate between people on the basis of their status, particularly in relation to "vulnerable or marginalized groups".⁴² As a state signatory to ICESCR, Australia is bound by the obligation to guarantee the right to health to all people within its jurisdiction. This obligation also operates in an extraterritorial context where people are under the effective control of the Australian state.

Australia's obligation under international law to provide decent healthcare to refugees and asylum seekers has also been recognised domestically. This obligation applies to both the provision of decent healthcare to people incarcerated in immigration detention facilities in Australia as well as to people subject to Australia's extraterritorial asylum regime in PNG and Nauru. In 2014, the Senate Legal and Constitutional Affairs Committee investigating an "incident" in the Manus Island RPC – during which 51 asylum seekers sustained injuries and one asylum seeker,

Iranian man Reza Barati, was killed by G4S guards in the course of mass guard violence in the detention centre – recommended that:

in accordance with the right to an effective remedy and right to health in international human rights law, the Australian Government [should] acknowledge and take responsibility for violations of human rights in relation to the incident at the Manus Island Regional Processing Centre...[and] provide compensation to those who have suffered human rights violations.⁴³

Despite these international obligations, the UNHCR has recently noted that many refugees and displaced persons globally face discriminatory barriers in accessing healthcare, as a result of "partial access, prohibitive out-of-pocket expenditures and other barriers including distance to facilities, language and provider acceptance".⁴⁴ Such discriminatory barriers work against the accessibility of health-based information and physically accessible and affordable healthcare, entitlements that are clearly established by the UN Committee on Economic, Social and Cultural Rights General Comment No 14.⁴⁵

2.3. Outsourcing Healthcare to Private Service Providers

"The psychologist is a torturer...I preferred to stay in my room for all the time, 23 hours, that's better than to see the psychologist in the Park and in the Mantra prisons. Because their words are full of negativity – have you thought about going back to your country? What do you want – this policy is the same. And when we asked about why we were locked up, 'We don't know, we just follow the rules. It's all about ABF.' Imagine these kind of words everyday in the brains of refugees, and on the other side the officers walk around the narrow white corridors, around the rooms, and it's a kind of white torture and a kind of mental torture that they are suffering. Each one of these refugees are really traumatised, and they need medical help."

– Mostafa Azimitabar, Kurdish refugee, Park Hotel survivor and human rights advocate

Primary healthcare and mental health services in Australia's immigration detention regime – both in Australia and in the context of "regional processing" – are provided by private entities under a variety of contractual arrangements.

⁴⁰ *International Covenant on Economic, Social and Cultural Rights*, 993 UNTS 3 (1976), article 12 (emphasis added).

⁴¹ UN Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (Art. 12), UN Doc E/C.12/2000/4 (2000).

⁴² *Ibid.*

⁴³ Legal and Constitutional Affairs References Committee, Australian Senate, *Incident at the Manus Island Detention Centre from 16 February to 18 February 2014* (December 2014), xi.

⁴⁴ United Nations High Commissioner for Refugees, *UNHCR Global Strategy for Public Health: 2021-2025* (August 2021), 6, <https://www.unhcr.org/612643544.pdf>.

⁴⁵ UN Committee on Economic, Social and Cultural Rights, *General Comment No. 14*.

International Health and Medical Services Pty Ltd (IHMS) has been contracted by Australia's Department of Immigration to deliver health services in immigration detention facilities in Australia in some capacity since 2003, including at the Christmas Island IDC.⁴⁶ IHMS has also been the primary provider of health services under Australia's extraterritorial immigration detention regime since its reinstatement in 2012. IHMS is a subsidiary of International SOS (Australasia) Pty Ltd, which is wholly owned by AEA International Holdings Pty Ltd, a Singaporean company.⁴⁷ IHMS markets themselves as a provider of 'healthcare services in challenging environments'. In practice, this includes providing healthcare services outside of detention facilities in relation to "consular services".

In terms of health services, within each immigration detention centre IHMS have a health service ostensibly led by a nurse with some specialist expertise in, for example, mental health.⁴⁸ As per the 2013 contract between IHMS and the Department of Immigration and Border Protection, the "overarching philosophy" that underlies the provision of healthcare in immigration detention is ensuring asylum seekers and refugees have access to healthcare "that is sufficient to maintain optimal health", "that is the best available within the circumstances" and "broadly comparable with health services available within the Australian community".⁴⁹ The contract also broadly outlines that healthcare "must be delivered without any form of discrimination, and with appropriate dignity, humanity, cultural and gender sensitivity".⁵⁰ The Public Interest Advocacy Centre also notes that if the IHMS health service determines that it cannot provide specialist healthcare, then there is capacity for referrals to other providers.⁵¹

One example of such a referral is the IHMS subcontract to Overseas Services to Survivors of Torture and Trauma (OSSTT) to provide torture and trauma counselling services in immigration detention centres in Nauru and PNG. OSSTT is a non-government, not-for profit organisation that was established in 2013 by members of the Forum of Australian Services for Survivors of Torture and Trauma to enable counselling support for asylum seekers and refugees

detained "offshore".⁵² OSSTT provided these services in Papua New Guinea between 2014 and 2017. OSSTT also provided counselling services on Nauru from 2014, but this service provision stopped when the organisation was asked to leave Nauru by the Australian government during the COVID-19 pandemic.⁵³ Human Rights Watch note that OSSTT "officially only deals with previous trauma" and, thus, cannot officially provide counselling on trauma arising from the structures of immigration detention that are experienced in the present, and that are produced by the setting in which they are confined.⁵⁴

Two other key companies have entered into arrangements with the Australian government to provide healthcare under Australia's extraterritorial immigration detention regime. Aspen Medical Pty Ltd (Aspen Medical) was engaged to provide specialist medical services on PNG and Nauru, specifically during 2017 and 2018. Aspen Medical is an Australian company and, similarly to IHMS, provides healthcare services in "remote, challenging or under-resourced" settings.⁵⁵ In PNG, the Pacific International Hospital was charged with the delivery of health services in May 2018 by way of informal arrangement with the Australian government.⁵⁶

However these contracts do not provide a true picture of the medical care and support actually provided in practice, as outlined below.

2.4. A Legal Duty of Care under Australian Law

"I think it's really important to centre the experience of the people who are being most affected by these horrible policies, the people whose lives are being determined when you engage in court processes or need the help of doctors... it's so important that people get to tell their own stories."

– Anna Talbot, then Legal Manager, National Justice Project

46 Legal and Constitutional Affairs References Committee, *Inquiry into Serious Allegations of Abuse, Self-Harm and Neglect of Asylum Seekers in Relation to the Nauru Regional Processing Centre* (April 2017).

47 Paul Farrell, "IHMS, the Healthcare Giant at the Heart of Australia's Asylum System – Explainer" (The Guardian, July 21, 2015), <https://www.theguardian.com/australia-news/2015/jul/21/ihms-the-healthcare-giant-at-the-heart-of-australias-asylum-system-explainer>.

48 Public Interest Advocacy Centre, *Healthcare Denied*.

49 Rebecca de Boer, "Background Note: Health Care for Asylum Seekers on Nauru and Manus Island" (Department of Parliament, June 28, 2013), 18, https://parlinfo.aph.gov.au/parlInfo/download/library/prspub/2552945/upload_binary/2552945.pdf;fileType=application/pdf.

50 Ibid 3.

51 Public Interest Advocacy Centre, *Healthcare Denied*.

52 Overseas Services to Survivors of Torture and Trauma, <http://www.osstt.org.au>.

53 Ibid.

54 Human Rights Watch, "Australia: Appalling Abuse, Neglect of Refugees on Nauru," August 2, 2016, <https://www.hrw.org/news/2016/08/02/australia-appalling-abuse-neglect-refugees-nauru>.

55 Aspen Medical, "Aspen Medical," 2022, <https://www.aspenmedical.com/aspen-medical>.

56 Department of Home Affairs, "Incoming Chief Medical Officer Brief," FOI Request No FA 19/02/00754 (2019), <https://www.homeaffairs.gov.au/foi/files/2019/fa190200754-document-released.PDF>.

Australian courts have recognised that the Australian government holds a legal duty of care to people in immigration detention in Australia, and that this duty of care extends to the provision of healthcare.⁵⁷ What is less clear is how far this duty of care extends, in what circumstances the Australian government will have failed to adhere to its obligations, and what can be done about their lack of adherence.⁵⁸ This lack of clarity around scope and remedy exists in part because the legal duty of care has not been incorporated into legislation.⁵⁹ This failure to enact legislation is despite the Minister's clear powers under section 273 of the *Migration Act 1958* (Cth) to create rules around how immigration detention centres are regulated and operating.⁶⁰

In contrast, Australian courts are yet to recognise a broad legal duty of care in relation to the provision of healthcare to people detained under Australia's extraterritorial immigration detention regime. To date, such a legal duty of care has only been recognised in a limited form. This limited recognition first took place through *Plaintiff S99/2016 v Minister for Immigration and Border Protection*.⁶¹ This case arose because the Australian government had refused to transfer from Nauru to Australia a woman who required a pregnancy termination, as a result of being raped. Instead, the Australian government facilitated her travel to Port Moresby, PNG, for the termination procedure. The Federal Court of Australia held that the Australian government had a duty of care to refugees and asylum seekers on Nauru to procure a lawful and safe abortion, and legally compelled the plaintiff's transfer to Australia. It is as yet unclear whether this legal duty of care would extend further than the factual circumstances of that case.

2.5. Medical Transfers from "Offshore" Detention

"So apart from the geographical distance [of health clinics in the Nauruan and Manus Island RPCs], we've got inexperienced clinicians who work there, and extremely confusing infrastructure depending on who has control of facilities at any one time. Refugees and asylum seekers will go to Port Moresby hospital, be told they can only go to Pacific International Hospital.

People get sent away when they were on Manus Island, there was a medical centre that was only open for certain hours, until 5 o'clock, and after that there was a lot of confusion as to where people go".

– Dr Barri Phatarfod, *Doctors for Refugees*

Australian law recognises that a refugee or asylum seeker in a "regional processing country" may be brought to Australia for a "temporary purpose".⁶² Although the term "temporary purpose" is not legislatively defined, one common application of the term is for the purpose of medical treatment in circumstances where a refugee or asylum seeker will not receive satisfactory treatment in Nauru or PNG. The legislation also establishes that when refugees and asylum seekers are brought to Australia under such circumstances, they are considered "transitory persons" who are not entitled to apply for any substantive visa while in Australia. In effect, this means that they are prohibited from claiming asylum after they are transferred to Australia.⁶³ In addition, people transferred from Nauru or PNG to Australia for medical treatment have generally been held in closed immigration detention, community detention or detained in hotels as "alternative places of detention".

In the early stages of "offshore" detention, the Department of Home Affairs engaged its powers under the *Migration Act 1958* (Cth) in a fairly liberal way to bring refugees and asylum seekers to Australia for medical treatment. However, by mid-2014 the Department of Home Affairs had adopted a formal policy titled *Medical Transfers and Evacuations – Offshore Operating Procedures*.⁶⁴ This policy stipulated that in the context of medical evacuation from "offshore" detention centres to Australia, IHMS should only "recommend a medevac ... in rare cases", such as in "a critical incident or a medical emergency". This approach was affirmed in 2018 in a policy document titled *Health Care in Regional Processing Countries*.⁶⁵ This document affirmed that a refugee or asylum seeker must be in need of "critical and complex" medical treatment that cannot be treated in Nauru or PNG or alternatively must be facing "a life-threatening medical emergency".

Resulting from this restrictive approach on paper, many people were rejected by the Department of Home Affairs for transfer to Australia for medical treatment despite doctors having recommended such transfers take place.⁶⁶

57 Sara Dehm, Claire Loughnan, and Linda Steele, "COVID-19 and Sites of Confinement: Public Health, Disposable Lives and Legal Accountability in Immigration Detention and Aged Care," *University of New South Wales Law Journal* 44, no. 1 (2021): 60–103.

58 *Ibid.* 83.

59 Public Interest Advocacy Centre, *Healthcare Denied*.

60 *Ibid.*

61 *Plaintiff S99/2016 v Minister for Immigration and Border Protection* (2016) 243 FCR 17.

62 *Migration Act 1958* (Cth), section 198B.

63 *Migration Act 1958* (Cth), sections 198AH, 198B, 46A.

64 Department of Immigration and Border Protection, "Medical Transfers and Evacuations – Offshore Operating Procedures." In "Medical Transfers and Evacuations Offshore Operating Procedures and the Number of Babies Born During Regional Processing Arrangements – October 2013 to April 2018", FOI Request No. FA18/04/00848 (released November 1, 2018), <https://www.homeaffairs.gov.au/foi/files/2018/2018-180400848-documents-released.pdf>.

65 Department of Home Affairs, "Policy – Health Care in Regional Processing Countries", FOI Request No. 19/01/00423 (released April 12, 2019), <https://www.homeaffairs.gov.au/foi/files/2019/fa190100423-document-released.PDF>.

66 Public Interest Advocacy Centre, *Healthcare Denied*.

In response, refugees and asylum seekers protested, community campaigns were created and strategic litigation was engaged to compel the Australian government to transfer refugees and asylum seekers in need of urgent medical treatment from “offshore” immigration detention centres to Australia for care.⁶⁷ There were over 50 cases lodged in the Federal Court of Australia and they collectively resulted in hundreds of people who were in need of urgent medical care being successfully evacuated from “offshore” immigration detention centres to Australia.⁶⁸ In addition, public campaigns were run in order to bring publicity to this issue and create change, including law reform.

In light of this strategic litigation and general advocacy around the failings of the government to allow refugees and asylum seekers to access medical treatment in “offshore” detention, the *Home Affairs Legislation Amendment (Miscellaneous Measures) Act 2019* (Cth) was passed (known as the Medevac Law). The passing of this legislation was significant. Not only did it provide a new, much-needed pathway for refugees and asylum seekers in Nauru and PNG to access critical, life-saving medical treatment, it also represented a rare moment in which the Government lost control of the House of Representatives and the legislation was passed against the Government’s wishes. It amended the *Migration Act 1958* (Cth) to shift the decision-making capacity for medical transfers from being held by the Department of Home Affairs alone, to requiring recommendations from independent doctors. Under the Medevac Law, the process meant that if two doctors recommended a transfer to mainland Australia for medical reasons, the Minister had an obligation to make a decision to approve or refuse the request within 72 hours. Refusal could be issued on the basis of character or national security grounds. However, any transfer requests that the Minister refused were then to be considered by an Independent Health Advice Panel consisting of eight members. If the panel approved a request, the Minister could then only refuse the request a second and final time, based on specific character or national security grounds, rather than a broad statement to this effect.

On 4 December 2019 the Medevac Law was repealed by the Morrison government following their re-election. Although the Medevac Law has now been repealed, litigation initiated by refugees and asylum seekers asserting that the Minister of Immigration owes them a duty of care to provide adequate healthcare during their time in Nauru and PNG still remains on foot.

⁶⁷ Anna Talbot and George Newhouse, “Strategic Litigation, Offshore Detention and the Medevac Bill,” *UNSW Court of Conscience* 13 (2019): 85–90.

⁶⁸ Kaldor Centre, “Medical Transfers from Offshore Processing to Australia,” August 10, 2021, <https://kaldorcentre.unsw.edu.au/publication/medevac-law-medical-transfers-offshore-detention-australia>.

3. Brief Chronology of Healthcare in Australia’s Extraterritorial Asylum Regime

| Date | Event |
|------------------|--|
| August 2012 | The Australian government reinstates the use of “regional processing” as a policy in relation to certain asylum seekers who arrive in Australia unauthorised by boat. This policy had previously been in place between 2001 and 2007. |
| September 2012 | The Australian Department of Immigration and Border Protection contracts International Health and Medical Services Pty Ltd (IHMS) to provide health services to asylum seekers in immigration detention in Nauru and Papua New Guinea. |
| March 2013 | Immigration Health Advisory Group (IHAG) forms to provide the Minister with expert health advice and to replace the Detention Health Advisory Group. In August 2013, the Terms of Reference were expanded to include the provision of advice to “Offshore Processing Centres”. |
| July 2013 | The Australian government announces that all asylum seekers who arrive by boat will be sent to “offshore detention” and never be resettled in Australia. |
| December 2013 | The Minister discontinues IHAG and replaces the group with an Independent Health Adviser (formerly the IHAG Chair). |
| 2014 | IHMS subcontracts counselling services for people in immigration detention centres in Nauru and Papua New Guinea to Overseas Services to Survivors of Torture and Trauma (OSSTT). OSSTT stopped providing counselling services in Papua New Guinea during 2017 and on Nauru during the COVID-19 pandemic. |
| 3 February 2014 | National Inquiry into Children in Detention launched by then President of the Australian Human Rights Commission, Professor Gillian Triggs. The inquiry considered children’s health, development and wellbeing in immigration detention. This inquiry followed an earlier inquiry in 2004, titled <i>A Last Resort?</i> |
| 25 February 2014 | Ms Salima and her husband transferred from Nauru to Brisbane for an abortion (arranged by IHMS). |
| 26 June 2014 | The Department of Immigration and Border Protection releases <i>Medical Transfer and Evacuations: Offshore Operating Procedures</i> to IHMS, including details about transfers only being made in “rare cases”. |
| 5 September 2014 | Death of Hamid Khazaei (a refugee detained at the Manus Island RPC) from a treatable and preventable leg infection. |
| 3 October 2014 | Scott Morrison, then Minister for Immigration and Border Protection, announces an inquiry into allegations of physical and sexual abuse of asylum seekers and refugees on Nauru (the Moss Review). |
| March 2015 | Final Report of the Moss Review released. |
| July 2015 | The Overseas Medical Referral process extended, in line with Government of Nauru obligations, beyond Nauruan citizens to include refugees. On 30 July 2015, first transfer of a refugee for medical treatment from Nauru to Port Moresby, PNG. |
| January 2016 | Aspen Medical Pty Ltd contracted to provide obstetric and neonatal healthcare services at Republic of Nauru Hospital with a team advising the Department of Immigration and Border Protection on the need for obstetric and neonatal services on Nauru. These services were provided until January 2017. |
| 6 May 2016 | <i>Plaintiff S99/2016 v Minister for Immigration and Border Protection</i> successful on appeal. This landmark case held that the Australian government has a limited legal duty of care in relation to procuring a lawful and safe abortion for asylum seekers and refugees who are subject to its “offshore” detention regime. |

| Date | Event |
|-------------------|--|
| 2 November 2016 | The Department of Immigration and Border Protection established the Transitory Persons Committee to support decision-making in relation to transfers under s198B of the <i>Migration Act 1958</i> (Cth). |
| 31 March 2017 | IHMS ordered to cease providing health services at Manus Island RPC as staff found to be practising medicine without a licence from the Papua New Guinean Medical Board. |
| 31 March 2017 | Aspen Medical Pty Ltd contracted by the Department of Immigration and Border Protection to provide specialist medical services in Papua New Guinea. |
| 12 September 2017 | The Department of Immigration and Border Protection nominates Taiwan as a country that could receive refugees and asylum seekers detained on Nauru as medical transfers. |
| April 2018 | The Terms of Reference for Transitory Persons Committee affirmed that medevac transfers will be made in extremely limited circumstances, even if the standard of medical treatment is lower than in Australia. |
| 1 May 2018 | Pacific International Hospital charged with the delivery of health services (including counselling services) in Papua New Guinea by way of informal arrangement with the Australian government. |
| 6 May 2018 | Aspen Medical Pty Ltd contracted by the Department of Home Affairs to provide a child psychologist in Nauru. |
| 29 July 2018 | Aspen Medical Pty Ltd specialist team contracted to provide surgical capacity for refugees and transferees referred to the Republic of Nauru Hospital by IHMS. Contracted until 1 August 2018. |
| 8 November 2018 | Arrangement between the Australian government and Medecins Sans Frontieres in relation to the Nauru RPC ended. |
| 13 February 2019 | The Medevac Law passes with the <i>Home Affairs Legislation Amendment (Miscellaneous Measures) Act 2019</i> (Cth). This legislation came into effect on 2 March 2019. |
| 29 May 2019 | First medical transfer under new Medevac Law. Over the following 8 month period, 192 refugees and asylum seekers were transferred to Australia under the Medevac Law. |
| 4 December 2019 | Medevac Law repealed. |
| March 2020 | The Communicable Diseases Network Australia adopted COVID-19 guidelines in response to the pandemic and detention facilities, including immigration detention. |
| March 2020 | Experts urged the Australian government to release people detained in immigration detention centres on the basis of health risks associated with COVID-19. The Australian government confirmed that there would be no people released from detention on this basis. However, there was a slow, gradual release of individuals over the following two years. This caused anxiety amongst those who could not understand why they were not selected for release and others were. |
| September 2021 | Australia and Nauru sign a new agreement to continue their “regional processing” arrangement. |
| 22 May 2022 | Australian elections result in the Australian Labor Party forming the new government. While this new government has promised to provide a pathway to permanency for refugees currently on temporary protection visas in Australia, it remains committed to the broader framework of “regional processing” and “offshore” detention. This means that the current legal limbo for people who have been transferred to Australia from Nauru or PNG is likely to remain, for now. |

4. Health-Related Harms of Australia's Refugee Externalisation in Practice: Key Case Studies

Under Australia's asylum regime, many health-related harms, including when these are fatal, are the result of the failure to provide adequate medical care and interventions. The medical border is accordingly often experienced as the refusal or reluctance to provide services. This has been described as “non care”⁶⁹ and as a form of neglect which is intentional, despite appearing to be merely the failure to act.⁷⁰ Medical infrastructures tend to be woefully inadequate, leading to poor care or no care at all. This is especially the case under Australia's extraterritorial immigration detention regime, indicating that externalisation policies are distinctly more likely to produce harms than refugee processing systems conducted “onshore”. Neglect and “uncare” have pernicious effects, leading to suffering and death.⁷¹ People are dying in these Australian-run settings as a direct result of the failure to provide care: in short, they are dying of medical and other forms of neglect.

a) Inadequate Refugee Healthcare in PNG

“If you can imagine something so far away, and if there's a medical emergency and you need an evacuation, it's extremely difficult, because there's no medevac stationed on this tiny speck of an island. So when you need to have someone brought to Australia for any sort of a health emergency, you need to find a medevac plane available in Australia – with the pilot and the crew with the available flying hours – to do that trip to Nauru. And we saw that with the tragic death of Omid Masoumali, who self-immolated a few years ago, and it took 26 hours for a flight to even arrive there, let alone fly back, find a hospital. And sadly he passed away.”

– Dr Barri Phatarfod, *Doctors for Refugees*

Since its reopening in 2012, Australia has sent 4,183 people to be detained in Australian-run immigration detention in Nauru or PNG.⁷² Initially, women and children were also detained at the Manus Island RPC; however, following a UNHCR mission report, women and children were forcibly transferred to the Nauruan RPC instead.

On 7 August 2013, Iranian man Hamid Khazaei sought asylum in Australia. Hamid did not hold a valid visa and so was deemed an “unlawful non-citizen” by the Australian state. Hamid was detained, first on Christmas Island before being transferred to Manus Island RPC in PNG on 6 September 2013. After more than a year in detention, Hamid presented to the IHMS clinic on Manus Island on 23 August 2014. Hamid reported 2-days of flu-like symptoms, including a fever, body aches and a sore throat, and an infected sore on his leg. By mid-afternoon on 24 August 2014, he was vomiting, his heart rate and fever increased, and his blood pressure dropped. By that evening, he needed a wheelchair to access the bathroom and go outside. The IHMS clinic was unable to treat him and during the morning of 25 August 2014 the treating doctor ordered an evacuation.

It was only on 26 August 2014 that Hamid was transferred to Port Moresby. This transfer occurred after his condition had significantly deteriorated, with his medical team noting symptoms of sepsis and respiratory distress. Under the IHMS arrangement, the Department of Immigration and Border Protection was required to approve any medical transfers. This meant that Hamid's transfer could only take place after approval was obtained. Hamid was first transferred to Pacific International Hospital in Port Moresby, despite this hospital having no intensive care facility. On 27 August 2014, Hamid was medically evacuated from Pacific International Hospital to Mater Hospital in Brisbane, Australia. Despite being transferred from Pacific International Hospital, the medical team at the Mater Hospital received no handover from the PNG medical team. On 28 August 2014, Hamid was found by the medical team at Mater Hospital to have suffered a significant brain injury. Hamid was declared brain dead on 2 September 2014. Supportive care was withdrawn on 5 September 2014 and Hamid died at 24 years of age.

The subsequent coronial inquest found that Hamid's death was entirely “preventable” and that Hamid would have survived had his deteriorating health been properly diagnosed.⁷³ The coroner identified “significant flaws” in the process for treating and evacuating Hamid from Manus Island, including the critical delays caused by a “lack of a documented approval process”. The coroner noted that the Australian Government “retains responsibility for the care of persons who are relocated, for often lengthy periods, to offshore processing countries where standards of health care do not align with those in Australia” and that it was “incumbent on the Australian Government to implement sustainable systems for the delivery of health care that meet

69 Jonathan Xavier Inda, “Immigration Detention, Mismatched Medication and the Necropolitics of Uncare,” in *Mapping Deathscapes: Digital Geographies of Racial and Border Violence*, ed. Suvendrini Perera and Joseph Pugliese (Routledge, 2021), 183–98.

70 Claire Loughnan, “The Scene and the Unseen: Neglect and Death in Immigration Detention and Aged Care,” *Incarceration* 3 no. 2 (2022): 1–18.

71 Inda, “Immigration Detention, Mismatched Medication and the Necropolitics of Uncare,” 194.

72 Refugee Council of Australia, “Offshore Processing Statistics,” June 13, 2022. <https://www.refugeecouncil.org.au/operation-sovereign-borders-offshore-detention-statistics/2/>.

73 *Inquest into the Death of Hamid Khazaei*, No. 2014/3292 (Coroners Court, Queensland, July 30, 2018).

the requisite standard”.⁷⁴ The coroner concluded that the IHMS clinic in the Manus Island RPC fell below this requisite standard.

It is important to note that, in reaching this finding, the coroner found that the benchmark standard of care for refugees in “offshore” detention centres is that provided in a remote hospital in Cape York. What the coroner did not state, though, is that the majority of people who permanently live in Cape York are First Nations people. By engaging a remote health clinic that primarily serves First Nations peoples as the standard for required healthcare, the standard of care owed by Australia to refugees in “offshore” detention centres is equated with that provided to First Nations peoples in remote communities in Australia. As Dehm draws out, such an equivalence in relation to standards of healthcare is fundamentally connected to “racialised practices of state violence, incarceration and dispossession” which produce “lower health outcomes and life expectancies”.⁷⁵ This is an approach that is part of broader “institutions, structures, systems, and processes [that] operate to undermine Indigenous health and wellbeing”.⁷⁶ The provision of health services to First Nations people in Australia also plays an insidiously similar role in their deaths, such as that of Yamatji-Nanda and Banjima woman Ms Dhu, who tried to convince both police officers and medical practitioners that she was seriously unwell before her death in custody.⁷⁷ It is important to recognise that although Hamid’s death was found to be “preventable” and in breach of this proposed standard, the standard applied is by no means non-discriminatory. Rather, this standard offers the same limited provision of healthcare, or “necropolitics of uncare”,⁷⁸ to refugees in “offshore” detention that is afforded to First Nations people within the settler-colonial state.

b) Gendered Harms to Women Refugees in Nauru

“Women often have prior exposure to gender-based violence or family violence in their home country, they often escaped from patriarchal regimes, like me, that view women as second class citizens. But they ended up experiencing a variety of violence in detention regimes. The chain of violence can profoundly impact their resilience and of course their wellbeing. The

struggles of those women are multifaceted and not only limited to healthcare or indefinite detention. There are other factors that escalate their health crisis and influence their wellbeing. Some of them at the same time should cope with state violence, domestic abuse, gender-based violence, and so many other harassment and abuse in detention. So as you can see, violence is a significant risk to women’s health and can also result in mental illnesses and chronic health problems.”

– Dr Saba Vasefi, scholar, journalist, poet and human rights advocate

Australia’s failure to provide refugees in immigration detention with accessible and non-discriminatory healthcare has a gendered impact on refugee women and their health.⁷⁹ These gendered consequences are shown by the antenatal care and pregnancy termination experiences of refugee women on Nauru. Below we highlight two stories of refugee women who had delayed access to decent healthcare. These two stories are not uncommon stories, and exemplify the experiences of many refugee women impacted by the lack of healthcare and services on Nauru.

The first case study concerns a 37-year old pregnant refugee woman from Kuwaiti who was detained on Nauru. In early 2017, this woman experienced a number of pregnancy-related complications, including: her baby being in the breech position, signs of preeclampsia and a benign tumour on her uterus.⁸⁰ The medical evidence was that these complications were “life-threatening” and her treating doctors “begged” for her to be evacuated to Australia. Despite this medical advice, the Australian DIBP initially refused the requests for transfer and instead noted its preference for births to occur on Nauru.⁸¹ It was only after public outcry and dedicated advocacy campaigns that the Department of Immigration and Border Protection reversed its decision and allowed this woman to be evacuated to Australia for medical care.

The second case study concerns a refugee woman who was the applicant in *Plaintiff S99/2016 v Minister for Immigration and Border Protection*.⁸² She is a refugee woman from an undisclosed country in Africa who after arriving on Christmas Island by boat was deemed to be an “unlawful non-citizen” by the Australian state. As a result, she was forcibly transferred to and then detained in the Nauruan RPC between 19 October 2013 and 11 November 2014.

⁷⁴ Ibid.

⁷⁵ Dehm, “The Entrenchment of the Medical Border in Pandemic Times.”

⁷⁶ Chelsea Watego et al., “Black to the Future: Making the Case for Indigenist Health Humanities,” *International Journal of Environmental Research and Public Health* 18, no. 16 (2021).

⁷⁷ Michelle Bui et al., “At a Lethal Intersection: The Killing of Ms Dhu (Australia)” (Deathscapes: Mapping Race and Violence in Settler States, 2017), <https://www.deathscapes.org/case-studies/ms-dhu/>.

⁷⁸ Inda, “Immigration Detention, Mismatched Care and the Necropolitics of Uncare.”

⁷⁹ Saba Vasefi and Sara Dehm, “Refugee Women and the Gendered Violence of Australia’s Extraterritorial Asylum Regime on Nauru,” *Refugee Survey Quarterly* 41, no. 3 (2022) (forthcoming).

⁸⁰ Josh Butler, “Pregnant Refugee On Nauru To Be Finally Flown To Australia” (HuffPost, February 2, 2017), https://www.huffpost.com/archive/au/entry/pregnant-refugee-on-nauru-to-be-finally-flown-to-australia_a_21705956.

⁸¹ Ibid.

⁸² *Plaintiff S99/2016 v Minister for Immigration and Border Protection* (2016) 243 FCR 17.

After being found to be a refugee, she was released from detention into Australian-funded refugee accommodation in the Nauruan community whilst she awaited elusive permanent resettlement elsewhere. This woman also suffered from epilepsy. On 31 January 2016, she was raped while she was experiencing a seizure.

The case, *Plaintiff S99*, relates to her pregnancy as a result of being raped and her need to terminate the pregnancy. At the time, the termination of a pregnancy was illegal on Nauru.⁸³ Given this, in this case, the Australian government approved her transfer to Pacific International Hospital (PIH) in Port Moresby, Papua New Guinea to undergo the procedure. In *Plaintiff S99*, the court found that PIH did not have the necessary resources for this specialised procedure and sending this woman there would expose her to unsafe circumstances and a risk of further serious harm. A successful court injunction followed, with a finding that the Australian government has a duty of care in relation to the provision of safe and lawful abortions to refugees under Australia's extraterritorial asylum regime. As a result, she was medically evacuated to Australia to undergo the procedure. This case shows the importance of refugee-initiated legal action in compelling the Australian government to provide access to decent and safe essential healthcare.⁸⁴

c) Mental Health Harms to Children

"Children started becoming very very sick. There was the emergence of resignation syndrome, which is a condition where children and young adults basically go to bed and don't get up again. They effectively lose the will to live. So they stop eating, they stop talking, they stop toileting themselves, sometimes for weeks. They can suffer kidney failure or permanent neurological or cardiac damage if they don't get treatment, that was the medical advice that we had. There were also children who were attempting suicide repeatedly. It's not that these children aren't serious about their suicide attempts it's just that they're kids and they don't know what they're doing. This was terrifying stuff that was happening."

– Anna Talbot, then Legal Manager, National Justice Project

The impact of detention on children and young people's mental health is severe and harrowing. There is longstanding evidence of this: in 2001 a profoundly disturbing example of this emerged in relation to the health of Shayan Badraie, a young boy in immigration detention in mainland Australia (specifically, in Woomera and Villawood immigration detention centres) with his family, slowly became sicker, becoming mute and withdrawn during a prolonged period in detention. He refused to eat, and was slowly dying without intervention and removal.⁸⁵

Children in detention have participated in the inquiries held by the Human Rights Commission, submitting numerous accounts of the harms they have endured, and have shared their testimonies directly with the public through a Facebook page initially titled "Free the Children Nauru". One 17 year old asylum seeker, held in immigration detention on Christmas Island, submitted four poems to the AHRC's 2014 inquiry. One of them, "Dear Bird Send My Message", contains the following words:

Dear bird send my message.
Send an image of my eyes- to Abbott-
where tears are rolling like a river,
send my heart full of sorrow,
send my mind full of thoughts,
send him images of why I came.

Dear bird send my message.
Send my emotions to Morrison
who is enjoying my pain,
who does not think that I am a human being like him,
who thinks that i am just a number the waste of
population.⁸⁶

In an online article, a young person describes their ongoing, constant fears and feelings of invisibility and erasure as directly arising from their experiences when detained as a child on Christmas Island and Nauru.⁸⁷ They also explain the severe mental health impact on themselves and their siblings within detention, reporting "high levels of depression, anxiety and PTSD shaping our lives" and a continued anxiety and distrust towards medical professionals.⁸⁸ Despite these clear links between the detention of children and detrimental mental health impacts, the successful court injunctions in the cases of two children highlight the Australian government's active opposition to their evacuation to Australia to receive appropriate psychiatric care.

83 *Criminal Code (Nauru)*, ss. 224-226.

84 Talbot and Newhouse, "Strategic Litigation, Offshore Detention and the Medevac Bill."

85 Australian Human Rights and Equal Opportunity Commission, *Report of an Inquiry into a Complaint by Mr Mohammed Badraie*.

86 Anonymous, "Submission No 20 - Name withheld - 17 year old asylum seeker," *Australian Human Rights Commission National Inquiry into Children in Detention* (2014), 4, <https://humanrights.gov.au/sites/default/files/Submission%20No%202020%20-%20Name%20withheld%20-%2017%20year%20old%20asylum%20seeker.pdf>.

87 Anonymous, "What Australia Doesn't Know: My Lived Experience Living on Nauru as a Child Refugee" (Missing Perspectives, date unknown), <https://www.missingperspectives.com/home/livedexperienceonauru>.

88 Ibid.

The first of these cases is FRX17 as litigation representative for *FRM17 v Minister for Immigration and Border Protection*.⁸⁹ This case evidences the experiences of a young girl (not yet a teen) who was detained with her family on Nauru between 2013 and late 2014. After being assessed as a refugee, this young girl was released from detention but remained on Nauru with her family awaiting resettlement. By 2017 the young girl had attempted suicide, continued to express suicidal ideations and also exhibited signs of psychosis and restricted eating. The young girl directly linked these thoughts and feelings to the Australian government's actions. Despite a number of recommendations and requests for urgent transfer and evidence around the inadequacy of mental healthcare facilities on Nauru, requests for the young girl's transfer were rejected by the Department of Immigration and Border Protection. It was only after a successful court injunction that the Australian government was forced to approve the transfer.

The second of these cases is that of *AYX18 v Minister for Home Affairs* concerning a 10-year old Iranian boy.⁹⁰ The young boy arrived by boat with his mother in July 2013. He was deemed an "unlawful non-citizen" and so detained on Christmas Island before being forcibly transferred to Australian-run immigration detention in Nauru with his mother. After being assessed as a refugee, the young boy was released from detention but remained on Nauru. In 2013, his father had an accident and was transferred to Brisbane for medical purposes and held in immigration detention there. In late 2013, the young boy began to experience night terrors and by 2014 he expressed suicidal ideations and threats of self-harm. In 2017, a doctor recommended that the young boy be medically evacuated to Australia for a medical procedure for a testicular condition that was causing him pain. This recommendation was rejected. In 2018, the young boy attempted suicide. He was taken to hospital unconscious and then attempted suicide again in the hospital. Despite many recommendations by doctors for his urgent transfer to Australia, these requests were rejected by the Department of Immigration and Border Protection. As in the above case, it was only after a successful court injunction that the Australian government was legally compelled to transfer the young boy.

There are many other examples of children in mental health crises, as a result of their detention and the subsequent refusal of requests for medical evacuations or proper treatment. This includes pre-adolescent children being diagnosed with resignation syndrome, with for example, a 12-year old boy being eventually transferred from Nauru to Australia after refusing food for two weeks.⁹¹ His refusal to

eat was a consequence of the trauma of detention, yet it was only once his condition got to this stage, that intervention and support was deemed necessary by the Government. These stories reveal the clear and egregious harms to children arising from Australia's immigration detention system. These harms also exist alongside the deliberate failures of the Australian state to provide adequate access to appropriate healthcare once these harms manifest.

d) Hotels as Harmful "Alternative Places of Detention"

"When I came to Australia I thought I was going to start a new life and I was going to be free. But they put me in MITA detention centre, and after a few hours they said "we are going to send you to a hotel". And I thought a hotel is a good place. I was ready to start my life. And they took me to Mantra hotel in Preston, and they locked me up on the third floor of the Mantra hotel along with 65 other refugees. All our life was [being] locked up on the third floor, and 23 hours a day, I was inside a room. And the only time I was outside the room was the time I wanted to drink a cup of tea or talk with one of the refugees in the corridor or one of the rooms. There was not any way to go outside the building. There was no sunlight. Sometimes I took my arm outside the window – I could just open the window 10 centimetre. ... It was really horrible, I don't know how I could survive."

– Mostafa Azimitabar, Kurdish refugee, Park Hotel survivor and human rights advocate

Australia has frequently repurposed sites – not intended or designed for the purpose of detention – into detention sites. This has included hotels, hospital rooms and airport spaces. Under the Medevac Law, refugees who were transferred to Australia were detained in closed immigration detention as well as hotels and motels as so-called "alternative places of detention" (APODs). Despite being transferred to Australia for the purpose of medical assessment and treatment, many of these incarcerated refugees experienced and continue to experience discriminatory access to healthcare and poor health outcomes.

The poor access to health care in such sites has been detailed by Mardin Arvin who was transferred to Australia under the Medevac Law and detained in Park Hotel, Melbourne. Arvin described receiving no treatment in

⁸⁹ *FRX17 as litigation representative for FRM17 v Minister for Immigration and Border Protection* (2018) 262 FCR 1.

⁹⁰ *AYX18 v Minister for Home Affairs* [2018] FCA 283.

⁹¹ Ben Westcott, Jo Shelley, and Euan McKirdy, "12-Year-Old Refugee Boy Airlifted from Nauru to Australia for Medical Attention" (CNN, August 21, 2018), <https://edition.cnn.com/2018/08/21/australia/nauru-boy-airlifted-australia-intl/index.html>.

Australia for the mental health and sinus problems that he was medically evacuated for. He explained:

I still don't understand what Medevac means. Did our jailers ever intend to treat our problems? Is it that doctors don't have power against the system, and the system doesn't want us to have medical care?⁹²

Arvin also described the crowded conditions and lack of fresh air in Park Hotel, explaining that in October 2021 almost half of the refugees imprisoned there had tested positive to COVID-19. Arvin deemed these COVID-19 infections as “a painful insult” from “a system [that] tortures you for nine years without reason” and described vaccine hesitancy among detained refugees as the result of their justified distrust of the “torturous” system and medical practitioners.⁹³

The discriminatory access to medical treatment for refugees in APODs and the lack of access to healthcare following medical evacuation is also shown by the denial of dental treatment to another person detained in these conditions, Zahid Hussain. Zahid describes having “bleeding and receding gums” and symptoms of “extreme ongoing pain” while in detention in Park Hotel in Melbourne.⁹⁴ Instead of access to appropriate dental treatment, Zahid was only given mouthwash and pain medication. He was then told to self-fund his treatment. Yet after raising the requisite funds through an advocacy campaign, Zahid was still refused access to the treatment.⁹⁵ Amin Afravi was similarly denied healthcare in relation to a chronic skin condition after being medically evacuated to Brisbane's Immigration Transit Accommodation.⁹⁶ Amin found that his psoriasis dramatically improved when he washed in rainwater and that chlorine-infused tap water caused his skin to painfully burn and become inflamed. Despite this, Amin was not provided with access to the large rainwater tanks onsite but was told that he was only allowed to collect rainwater in a bucket and was unable to shower as a result.⁹⁷ These stories show how access to even basic healthcare is denied to refugees, even when they have been medically evacuated from PNG or Nauru to Australia for treatment.

e) Health-Related Harms after Release

It is clear that it is increasingly difficult to dispense adequate care, given the complexity and the gravity of the harms that detention produces. Over twenty years ago, in their 2001 landmark study, Steel and Silove found that the:

close association between administrative procedures and psychological reactions is particularly worrisome, as it endorses the concern that these procedures, in themselves, act to undermine the psychological well-being of detainees.⁹⁸

This suggests that administrative processes in this environment are inherently harmful, insofar as they are accompanied by anxiety about the outcome of their claims for protection: even the administrative procedures themselves constitute a *source* of harm in the way that they are exercised. The combination of this with a confined environment, the prior vulnerability of those detained, uncertainty and lack of clarity about the future, produce a toxic environment which is not conducive to care, and indeed which limits the capacity for those detained to achieve and or maintain a reasonable standard of mental and/or physical health. Such experiences contribute directly to much of the poor health that those detained begin to demonstrate. The failure to provide adequate medical care compounds these harms.

The ongoing trauma and suffering endured as a result of detention is well-recognised.⁹⁹ Importantly however, it persists long after release from detention. For example, Hartley and Fleay interviewed refugee men who were detained onshore for a period of between 11 and 25 months.¹⁰⁰ All of the men interviewed reported negative impacts as a result of their detention and their suffering continued long after their release into the community. They explore in detail the story of Hussain who was detained for 21 months in an onshore detention centre until his release into the community in January 2012. Hussain was previously detained on Nauru between 2001 and 2002 but was returned to Afghanistan after his claim for asylum was denied. After unsuccessfully attempting to find safety in other countries in the interim period, in 2010 Hussain

92 Mardin Arvin, “Can Our Jailers Provide Our Care?” (Overland, October 26, 2021), <https://overland.org.au/2021/10/the-park-hotel-refugees-and-the-withdrawal-of-healthcare-as-torture/>.

93 Ibid.

94 Tracey Shelton, “Park Hotel Detainees Housed alongside Novak Djokovic Describe ‘disgusting’ and ‘Cruel’ Conditions” (ABC News, January 9, 2022), <https://www.abc.net.au/news/2022-01-09/park-hotel-detainee-speak-out/100745456>.

95 Ibid.

96 Sowaibah Hanifie and Edwina Seselja, “Detained Asylum Seeker given Bucket to Shower, after Dispute with Authorities over Medical Treatment” (ABC News, February 23, 2021), <https://www.abc.net.au/news/2021-02-23/asylum-seeker-with-psoriasis-has-washed-in-weeks-tap-water-burns/13180610>.

97 Ibid.

98 Steel and Silove, “The Mental Health Implications of Detaining Asylum Seekers.”

99 Claire O'Connor, “The Impact of Detention on the Mental Health of Immigration Detainees: Implications for Failure to Deliver Adequate Mental Health Services - Who Cares?,” *UTS Law Review* 9 (2007): 125–44; Hartley and Fleay, “Released but Not Yet Free”; Mares and Jureidini, “Psychiatric Assessment of Children and Families in Immigration Detention”; Steel and Silove, “The Mental Health Implications of Detaining Asylum Seekers”; Steel et al., “Psychiatric Status of Asylum Seeker Families Held for a Prolonged Period in a Remote Detention Centre in Australia”; Aamer Sultan and Kevin O'Sullivan, “Psychological Disturbances in Asylum Seekers Held in Long Term Detention: A Participant-Observer Account,” *Medical Journal of Australia* 175, no. 11 (2001): 593–96; Mares and Zwi, “Sadness and Fear”; Joint Select Committee on Migration, *Final Report on the Immigration Detention Network 2012*; Zachary Steel et al., “Two Year Psychosocial and Mental Health Outcomes for Refugees Subjected to Restrictive or Supportive Immigration Policies,” *Social Sciences and Medicine* 72 (2011): 1149–56.

100 Hartley and Fleay, “Released but Not Yet Free”.

returned to Australia. Hussain was finally recognised as a refugee in 2012, but describes “long-term detention as being filled with despairing moments”.¹⁰¹ Hussain also describes how the continued impact of detention on both his physical and mental health impacted “his ability to cope with living in the community” after his release.¹⁰²

This description of continued suffering is also supported by a systematic review of all quantitative literature on the impact of immigration detention on the mental health of refugees and asylum seekers.¹⁰³ In their study of this literature, von Werthern et al found that mental health problems were higher in adults, young people and children who had been detained than in refugees who had not been detained. They also found that longer periods of detention equated with a greater severity of symptoms. These findings are a serious indictment on the mental health impact of Australia’s detention regime. As noted above, the average length of time refugees are detained for in Australian-run immigration detention centres in Australia, Nauru or PNG is in stark contrast to other countries.

f) Disability and the Compounding Harms of Immigration Detention

“My suggestion is for an intersectional approach. An intersectional approach is necessary to care about violence against women refugee and legitimise refugee women as a women’s right. I found the most challenging issue is the lack of multifaceted approach to identify the complexity of displacement for women and then to respond to their needs.”

– Dr Saba Vasefi, scholar, journalist, poet and human rights advocate

Australia’s detention regime is driven by a logic that has been described by philosopher and queer theorist Jasbir Puar as “the right to maim”.¹⁰⁴ Vasefi and Dehm show how these logics operate to harm when they describe Nasreen’s experiences.¹⁰⁵ Nasreen is a 53 year old woman in need of an ongoing carer, who fled Afghanistan with her adult children to join her husband Mohammad in 2013.¹⁰⁶ Mohammad had been living in Australia since 2012 after he was recognised to be a refugee and provided with a permanent visa

Because Nasreen and her children arrived by boat, they were deemed “unlawful non-citizens” and initially detained on Nauru. In 2014, Nasreen was medically evacuated to Australia with her daughter to receive treatment for injuries sustained when she was severely beaten by the Taliban in Afghanistan, and her other children were transferred to Australia a few years later. Although all of the family were then located in Australia, Mohammad was not allowed to live with Nasreen and their children because of his visa status. Nasreen explains that

after four years of separation from my children who were on Nauru, now the government wants to split me from my husband who is also my carer. It is not resettlement, but a forced separation for an elderly woman with multiple disabilities and in need of extensive support.¹⁰⁷

This story clearly shows the punitive logics of Australia’s detention regime and how such logics are prioritised above the health and safety of refugees, including those with a disability. This approach also fits within Australia’s historical and contemporary immigration system that has been, and is, imagined through both racist and ableist logics. The Refugee Council of Australia’s 2019 report on *Barriers and Exclusions: The Support Needs of Newly Arrived Refugees with a Disability* shows that Australia’s refugee program actively discriminates against disabled people.¹⁰⁸ Dominic Hong Duc Golding also explains that there is a thorough lack of understanding and support within disability services for refugees and asylum seekers, while refugee support services have little understanding or support for disabled refugees – many of whom understand and explain their situation in terms outside the western frameworks that Australia offers.¹⁰⁹

As Soldatic suggests, First Nations people and disabled people were denied by the Australian settler-colonial state “first at its initial claim for statehood, then as a white able-bodied nationalist project of a future imagined state”.¹¹⁰ In this way, ableism within the immigration system is connected to “the imaginary of the white-settler colonial nation-state”.¹¹¹ The stories of Nasreen and others show that such processes continue to exclude refugees from safety and disallow access to necessary support and care.

101 Ibid 13.

102 Ibid.

103 M. von Werthern et al., “The Impact of Immigration Detention on Mental Health: A Systematic Review,” *BMC Psychiatry* 18, no. 1 (2018): 382.

104 Jasbir Puar, *The Right to Maim: Debility, Capacity, Disability* (Duke University Press, 2017).

105 Vasefi and Dehm, “Refugee Women and the Gendered Violence of Australia’s Extraterritorial Asylum Regime on Nauru.”

106 Ibid.

107 Ibid.

108 Refugee Council of Australia, *Barriers and Exclusions: The Support Needs of Newly Arrived Refugees with a Disability* (February 2019), <https://www.refugeecouncil.org.au/disability-report/>.

109 Dominic Hong Duc Golding, “Ex-Detainees, Asylum Seekers and Refugees with Disabilities: Our Needs and Perceptions of Disability” (RISE Public Advocacy Paper, 2018).

110 Karen Soldatic, “Postcolonial Reproductions: Disability, Indigeneity and the Formation of the White Masculine Settler State of Australia,” *Social Identities* 21, no. 1 (2015): 63.

111 Ibid.

5. Implications of Australia's Refugee Externalisation Practices for Refugee Health

5.1. Deteriorating Health Outcomes

A key implication of Australia's punitive extraterritorial asylum regime is the deteriorating health of refugees and asylum seekers who have been subject to this regime. Advocates and researchers have long been concerned with the mental health impact of Australia's policy and practice of mandatory immigration detention. For example, over two decades ago, Steel and Silove were already calling for the urgent examination of immigration detention and its impact on the mental wellbeing of refugees and asylum seekers, a group with a particular history of torture and trauma.¹¹² In more recent years, studies have shown how self-harm emerges as a consequence of Australian immigration detention both "onshore" and "offshore".¹¹³ In considering governmental data on incidents of self-harm within immigration detention facilities in Australia, Hedrick et al found 959 incidents of self-harm were reported across a 20 month period to May 2011.¹¹⁴ That number of incidents correlated to a 22% self-harm rate, with conditions in immigration detention existing as the most common "precipitating factor".¹¹⁵ Common conditions included transfers between facilities, material conditions inside immigration detention and delays associated with healthcare.¹¹⁶ In another study, Hedrick et al report a lack of appropriate governmental data being captured around self-harm among asylum seekers, including in immigration detention centres "onshore" and "offshore".¹¹⁷ They also found limited compliance by the Australian government with self-harm reporting guidelines from the World Health Organisation.¹¹⁸ With such significant rates of self-harm directly linked to the conditions in immigration detention, alongside poor reporting practices by the Australian state despite this high self-harm rate, the detrimental impact on the mental health of those detained is evident.

There is also limited but clear research that shows how the psychological wellbeing of people in detention is influenced

by gender, location and length of time in detention. Rivas and Bull adopt a specifically gendered lens when analysing publicly available data from reports on immigration detention by the Australian Commonwealth Ombudsman.¹¹⁹ Their sample included 54 women who, on average, had spent nearly three years in detention. Of these women, 88.9% experienced at least one mental health concern, over half had threatened, thought about or engaged in self-harm. Additionally, the mental health of nearly a quarter of those detained deteriorated during detention, and feelings of sadness, isolation and hopelessness were also pervasive. Rivas and Bull have used these findings to highlight the detrimental impact of long-term detention on women's mental health and situate these impacts within women's specific histories of torture and trauma as asylum seekers.¹²⁰ In arguing for an end to Australia's "offshore" detention regime, Essex et al also found that the impact of detention on the mental health of those detained increases with the length of time spent in detention.¹²¹ Furthermore, they found that psychological distress experienced by people in detention is worse when people are detained in "offshore" detention centres, specifically on Manus Island and in Nauru.¹²² This research suggests that immigration practices particular to Australia's extraterritorial detention regime, such as length of time detained and the "offshore" locations, are especially detrimental to the health of people detained.

5.2. Poor Health as Punishment

Another key implication of Australia's extraterritorial asylum regime – and in particular the extensive use of immigration detention both within Australia and extraterritorially – is that poor health consequences are part of the punitive nature and consequences of this regime. This is clearly shown, for example, in the context of refugees who are detained in APODs. As detailed above, the material conditions within APODs, including the limited access to fresh air or decent healthcare, function to create a particularly punitive setting in which a person's deteriorating health is experienced as part of this architecture of punishment. In comparing the public rhetoric around Australia's policy of hotel quarantine during COVID-19 with the experiences of refugees in hotel detention, Loughnan, for example, has shown how

¹¹² Steel and Silove, "The Mental Health Implications of Detaining Asylum Seekers."

¹¹³ Kyli Hedrick, "Getting Out of (Self-) Harm's Way: A Study of Factors Associated with Self-Harm among Asylum Seekers in Australian Immigration Detention," *Journal of Forensic and Legal Medicine* 49 (2017): 89–93; Kyli Hedrick et al., "An Evaluation of the Quality of Self-Harm Incident Reporting across the Australian Asylum Seeker Population According to World Health Organization (WHO) Guidelines," *BMC Psychiatry* 20, no. 1 (2020): 301.

¹¹⁴ Hedrick, "Getting out of (Self-) Harm's Way."

¹¹⁵ *Ibid.* 89.

¹¹⁶ *Ibid.* 92.

¹¹⁷ Hedrick et al., "An Evaluation of the Quality of Self-Harm Incident Reporting."

¹¹⁸ *Ibid.*

¹¹⁹ Lorena Rivas and Melissa Bull, "Gender and Risk: An Empirical Examination of the Experiences of Women Held in Long-Term Immigration Detention in Australia," *Refugee Survey Quarterly* 37, no. 3 (2018): 307–27.

¹²⁰ *Ibid.*

¹²¹ Ryan Essex et al., "Psychological Distress in Australian Onshore and Offshore Immigration Detention Centres from 2014–2018," *Journal of Immigrant and Minority Health* (2022) <https://doi.org/10.1007/s10903-022-01335-7>.

¹²² *Ibid.*

refugees experience these conditions as “torturous”.¹²³ Such “torturous conditions” continue even after people have been released from APODs, with refugees still subject to legal limbo and economic precarity in the community, including without access to appropriate healthcare and other essential services.¹²⁴

These concerns about the use of hotels as sites of punitive detention are not new. For example, in 2009, Joseph Pugliese detailed how Australia’s use of hotel rooms as places of detention transformed seemingly “neutral” spaces into spaces of punitiveness, “punishment” and “pain”.¹²⁵ He concluded that the civility of these spaces is “particularly intolerable. . . [because] it destroys the hope that there might be the possibility to occupy another space the civic that is not generative of trauma and violence”.¹²⁶ Pugliese recounted the story of Ali Beyazkilinc to highlight the experiences of these alternative spaces of detention.¹²⁷ Beyazkilinc experienced mental ill health during his detention in a hotel room in 2006. Beyazkilinc was transferred multiple times from hotel detention and back to closed immigration detention facilities despite medical advice to the contrary. As Pugliese notes, Beyazkilinc was moved “within a circuit of transfers from one institution to another and back again that only exacerbate[d] his mental instability”.¹²⁸

The treatment of refugees in closed immigration detention in Australia during the COVID-19 pandemic was also experienced as a form of punishment. As has been extensively documented, Australia put drastically inadequate preventative measures in place within such carceral settings to protect people from COVID-19 infections. This illustrates a clear disparity between the measures adopted for citizens and the failure to extend this to those at the margins. Rather than choosing to release people into the community in accordance with medical advice, refugees were exposed to policies of “hyper-incarceration”, “overcrowding” and could not engage in “individual-level preventative behaviours”.¹²⁹ Australia’s clear failure to consider alternative forms of accommodation that allow for safe social distancing not only increased the risk of COVID-19 harms for incarcerated refugees. It also articulated

a logic of “exclusion” and “disposability” towards refugees, positioning them as people less worthy of protecting in the context of a global pandemic.¹³⁰ As one refugee detained in Villawood immigration detention centre stated, refugees effectively became “sitting ducks for COVID-19”.¹³¹

5.3. Exposure to Death

A further key implication of Australia’s punitive use of healthcare in its extraterritorial asylum regime is that it exposes refugees and asylum seekers to death. This finding draws on Cameroon scholar Achille Mbembe’s concept of necropolitics that explores how the contemporary racist logics of sovereignty deem certain people’s lives “disposable” through their exposure to death.¹³² Dehm argues that the death of Iranian refugee Hamid Khazaei demonstrates “the failure of states adequately to care for him”.¹³³ In so doing, she suggests that necropolitical violence towards incarcerated refugees is articulated “in part through the [racialised] denial of adequate healthcare” within broader state border regimes.¹³⁴ Loughnan likewise shows how Hamid Khazaei’s death was the product of “myriad, small inactions” that evidence a structural neglect on the part of Australia.¹³⁵ For Loughnan structural neglect, specifically the failure to provide adequate healthcare, is directly connected to the “necrositic” functioning of immigration detention.¹³⁶ These approaches also align with the work of Jonathan Inda who shares the devastating story of Juan Carlos Baires who died as a result of mis-medication for his pre-existing condition of HIV when he was detained in a US immigration prison.¹³⁷ In retelling Juan Carlos’s story, Inda develops the concept of the “necropolitics of uncare”, where refugees in immigration detention are faced with death because of the racialised lack of healthcare that is afforded to them.¹³⁸ Such practices reveal the way that neglect functions as an action designed to inflict harm, that ultimately risk death.¹³⁹

It is also relevant to note that experiences of being “exposed to death” are made manifest by the engagement by refugees and asylum seekers in embodied responses of resistance to

123 Claire Loughnan, “Not the Hilton: ‘Vernacular Violence’ in Covid-19 Quarantine and Detention Hotels,” *Arena Quarterly* (2020).

124 Sara Dehm and Claire Loughnan, “Scores of Medevac Refugees Have Been Released from Detention. Their Freedom, Though, Remains Tenuous.” (The Conversation, March 22, 2021) <https://theconversation.com/scores-of-medevac-refugees-have-been-released-from-detention-their-freedom-though-remains-tenuous-156952>.

125 Joseph Pugliese, “Civil Modalities of Refugee Trauma, Death and Necrological Transport,” *Social Identities* 15, no. 1 (2009): 149–65. See page 158.

126 Ibid.

127 Ibid.

128 Ibid.

129 Anthea Vogl et al., “COVID-19 and the Relentless Harms of Australia’s Punitive Immigration Detention Regime,” *Crime, Media, Culture: An International Journal* 17, no. 1 (2021): 43–51.

130 Dehm, Loughnan, and Steele, “COVID-19 and Sites of Confinement.”

131 Rebekah Holt and Saba Vasefi, “We Are Sitting Ducks for Covid 19: asylum seekers write to PM after detainee tested in immigration detention”, (The Guardian, March 24, 2020) <https://www.theguardian.com/australia-news/2020/mar/24/we-are-sitting-ducks-for-covid-19-asylum-seekers-write-to-pm-after-detainee-tested-in-immigration-detention>.

132 Achille Mbembe, “Necropolitics,” trans. Libby Meintjes, *Public Culture* 15, no. 1 (2003): 11–40.

133 Sara Dehm, “International Law at the Border,” in *Routledge Handbook of International Law and the Humanities*, ed. Shane Chalmers and Sundhya Pahuja (Routledge, 2021), 341–56.

134 Dehm, Loughnan, and Steele, “COVID-19 and Sites of Confinement,” 347.

135 Loughnan, “The Scene and the Unseen,” 11.

136 Ibid.

137 Inda, “Immigration Detention, Mismatching and the Necropolitics of Uncare.”

138 Ibid 184.

139 Loughnan, “The Scene and the Unseen.”

violent practices within immigration detention.¹⁴⁰ Studies show that refugees at times engage in hunger strikes as a form of resistance to racialised biopolitical control and necropolitical harms evident in immigration detention settings.¹⁴¹ In many respects, immigration practices have impelled these embodied forms of resistance.¹⁴² Such protests have also occurred under Australia's brutal policy of extraterritorial detention, including at the time of the decommissioning of the Manus Island RPC. During their three week standoff in opposition to state attempts to move them to another prison, refugees on Manus Island engaged in an "embodied protest" through which "the men asserted a form of autonomy against the authorities that had controlled their lives", despite "enduring starvation, infections, threats and incursions".¹⁴³ In response to refugee externalisation regimes and immigration detention systems that expose refugees to death, refugees themselves strategically use their bodies in order to challenge the racist and colonial violence of these very systems.

6. Key Findings and Recommendations

"I think refugees themselves are the most powerful advocates. I have been inspired by them, I have been energised by them."

– *Dr Saba Vasefi, scholar, journalist, poet and human rights advocate*

This report makes the following key findings in relation to the health-related harms of Australia's refugee externalisation regime and Australia's use of healthcare within practices of refugee externalisation:

1. Immigration detention, "regional processing" and state border regimes in general *cause health-related harm*, including deteriorating health outcomes.
2. Immigration detention and "offshore" detention function as places of punishment.
3. Immigration detention and "regional processing" are systems that expose people to death.
4. The health-related harms of immigration detention and "regional processing" persist long after release.
5. People seeking refuge remain powerful advocates for their own rights, including in exposing the health-related harms of state border regimes and advocating for the provision of decent healthcare.
6. Decent healthcare cannot be provided within the context of immigration detention or "regional processing".
7. The Australian Government has an ethical responsibility to provide reparations – in the form of financial compensation and an apology – to people who have experienced health-related harms from Australia's refugee externalisation practices, including from Australia's failure to provide decent healthcare in Australian-run immigration detention.

Taken together, these findings necessitate the immediate end to Australia's use of immigration detention and "regional processing", and to the violence of state border regimes more generally.

¹⁴⁰ Samantha O'Donnell, "Living Death at the Intersection of Necropower and Disciplinary Power: A Qualitative Exploration of Racialised and Detained Groups in Australia." *Critical Criminology* 30 (2022): 285–304.

¹⁴¹ Michelle Pfeifer, "Becoming Flesh : Refugee Hunger Strike and Embodiments of Refusal in German Necropolitical Spaces," *Citizenship Studies* 22, no. 5 (2018): 459–74.

¹⁴² Ibid.

¹⁴³ Sara Dehm, "Outsourcing, Responsibility and Refugee Claim-Making in Australia's Offshore Detention Regime," in *Profit and Protest in the Asylum Industry*, ed. Siobhan McGuirk and Adrienne Pine (PM Press, 2019), 13.

7. Author Bios

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8. List of Abbreviations

AHRC: Australian Human Rights Commission

APODs: Alternative Places of Detention

DIBP: Department of Immigration and Border Protection, Australian Government

IHAG: Immigration Health Advisory Group

IHMS: International Health and Medical Services Pty Ltd

OSSTT: Overseas Services to Survivors of Torture and Trauma

PIH: Pacific International Hospital, PNG

PNG: Papua New Guinea

RPC: Regional Processing Centre

UN: United Nations

UNHCR: United Nations High Commissioner for Refugees

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