Physical and Mental Health Subcommittee of the Joint Advisory Committee for Nauru Regional Processing Arrangements

Nauru Site Visit Report

16-19 February 2014

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Executive summary

The purpose of the subcommittee visit was to provide assessment, commentary and recommendations on issues affecting the physical and mental health of people ('transferees') in held detention on Nauru. We are grateful for the support provided for our site visit by the Government of Nauru (GoN), the Australian Department of Immigration and Border Protection (DIBP) and other stakeholders, including Transfield, Wilson Security, Save the Children (STC), Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS) and International Health and Medical Services (IHMS). We would like to acknowledge and thank the government officials, community representatives and stakeholder staff for their input and time. During the visit, it was apparent there are many people working to improve outcomes for the people in held detention on Nauru.

There are currently 1092 people in held detention. There are 655 people in RPC3 – including 144 children aged 4 – 17 years, 10 unaccompanied minors, and 110 women. There are 437 men in RPC2. There are around 1300 RPC staff on island, 53% of staff are Nauruan. The combined numbers of non-Nauruan staff and people in held detention represents a 17.5% increase in the total population of Nauru

People have been in held detention for up to 18 months, the mean duration was not available. Processing of Refugee Status Determination (RSD) claims commenced in January 2014, and is continuing. There have been no Refugee Status Determination claims granted; planning is underway to establish a refugee review tribunal. There is considerable uncertainty around future planning - there are no clear plans for risk minimisation following RSD decisions (either positive or negative) and no clear plans for settlement following positive RSD decisions.

There are substantial ongoing risk factors for physical and mental health problems in people in held detention on Nauru. These include:

a) **Crowded, hot and humid living conditions in an enclosed detention environment with minimal access to meaningful activities, for prolonged periods, with uncertain endpoints.** Adults described boredom, hopelessness and helplessness, and very limited access to activities. Many people described an overwhelming sense of uncertainty about progress, and information dissemination was repeatedly identified as an issue. Children have limited meaningful play and reduced hours of schooling in difficult conditions without monitoring systems. Parenting is difficult, and the nature of the infrastructure fosters dependency. Together, these factors are likely to cause and maintain mental health problems and more generally, lead to widespread hopelessness and boredom with the potential for unrest. This is likely to be exacerbated by the impending change of the welfare and case management contract to a stakeholder with limited experience in this area, delays in refugee status determination process, and the lack of clarity around settlement planning or risk minimisation following outcome delivery.

b) **Issues with information transfer and ongoing provision of updates** – to the RPC population and the local community, leading to uncertainty, distrust and potential for destabilisation. The lack of direct engagement with local communities and the relative separation of the RPC from the local community are also concerning in the context of any proposals of settlement.

c) **A lack of clarity on mental health screening and consequent actions, and low numbers of people on active Psychological Support Program (PSP) despite critical issues with self-harm.**

Over the 14 months (9/2012 –11/2013) there were 102 incidents of self harm in adult males, including 28 attempted hangings/asphyxiations in 18 individuals, and five people who had cut their neck and throat. In total, there were 24 transfers and nine emergency medical evacuations to Australia. The potential for clusters of harm and the secondary impact on other people including children, and staff should be considered as additional risk factors for mental health problems.

d) **Gaps in physical health screening systems including a lack of health screening in children** – there are inefficiencies in adult health screening with 'rapid turnaround' policies resulting in people being returned to Australia, and there is a lack of health screening in children, which is not appropriate in the situation of transfer to an offshore processing environment. While the screening protocols described in the DIBP detention screening protocol are sound, these are not implemented within IHMS procedures, meaning there is only a limited history and examination for children aged under eleven years, and no blood screening for children aged under fifteen years. These age delineations are based on offshore health screening protocols intended to exclude active tuberculosis disease and establish 'fitness to fly', however they are not appropriate for a held detention setting. Based on current prevalence data, there are likely to be multiple children with undiagnosed blood borne virus infections such as hepatitis B, and up to 50% of children will have latent tuberculosis infection with their risk of developing active tuberculosis increased by young age, recent migration and social stressors, all of which are relevant in this setting. Currently there is no child developmental surveillance, which is also an important form of mental health monitoring. The lack of child health screening means health issues and disability are likely to arise after transfer.

e) **Possible gaps in immunisation provision** – IHMS reported that immunisation catch-up has been provided; however the reports of people in detention suggest incomplete immunisation, and we were not permitted to review documentation. Incomplete immunisation is an avoidable risk factor for outbreaks of vaccine preventable diseases such as measles, mumps, rubella, chicken pox, pertussis and influenza, which are more likely in close living conditions.

f) **Gaps in child health expertise and services** – there is a lack of paediatric health expertise within IHMS, and lack of resuscitation support for infants and children. There are no paediatricians in IHMS, there are no staff with acute paediatric life support training, there is inadequate experience in paediatric resuscitation, and there is no facility for advanced paediatric life support at the Republic of Nauru hospital. Children deteriorate quickly when they are unwell, and the 24 – 36 hour timeframe for medical evacuation will not allow support during the critical early period of a severe illness. There is only one paediatrician providing care for Nauruan children, and there is the potential for difficult decisions on resource allocation, for example with only a single neonatal incubator within the hospital. One baby in 37 dies in the neonatal period in Nauru.

g) **The risk of child protection issues and lack of child protection capacity -** there is a significant and ongoing risk of child abuse, including physical and sexual abuse, in the detention environment where large numbers of children and adults are held in crowded conditions without normal social structure or meaningful activities. There is a lack of staff experience in child protection and there is a lack of clarity on the IHMS, stakeholder, and local processes for managing and investigating child protection issues. Nauru does not currently have a child protection framework.

h) **Challenges in delivering maternal services –** the Nauruan maternal mortality ratio is 35 times higher than the comparative value for Australia, and further understanding of this disparity will be important to address any modifiable risk for both mothers and infants. To date, pregnant women have been transferred to Australia, and it appears that most pregnancies are categorised as high risk, through either mental or physical health concerns. The lack of blood bank support is reported to be a contributor to maternal morbidity and mortality, although it would not be straightforward, and may not be possible, to support a blood bank on Nauru with requirement for expertise, equipment, storage, and stable power.

i) **Gaps in health service access, and system inefficiencies,** which may delay presentation and proactive health and mental health care. The IHMS failure to attend appointment rate is 25 – 30% suggesting inefficiency in the appointment booking and support process. There were consistent reports across both RPCs of long waiting times for appointments, and of having to make multiple requests for appointments. There have been 53 medical transfers for mental and physical health issues over the 12 months of 11/2012 – 11/2013, representing significant cost. Dental service access is identified as an area of particular concern, with 240 people on a waiting list. Other risks include the differential health screening for children and adults, challenges with data management, and that only basic pathology tests are available on Nauru, blood cultures are not available, and any complex tests are sent to Australia.

j) **Public health concerns** including

   i. **Reports of Dengue fever** in Nauru that require clarification - with implications for health services, site management and vector control. There are some vector control measures in place.
   ii. **The potential for groundwater contamination** through effluent disposal and waste management with consequent risk of communicable disease transmission.
   iii. **The potential for communicable disease outbreaks** noting limited screening in children, lack of screening for latent tuberculosis infection, possible issues with immunisation, some challenges with access to condoms, and close living conditions which will amplify transmission of airborne, vector-born or faecal-orally transmitted pathogens.
   iv. **The lack of a formal agreement between the two governments on criteria for excluding transfer.** There is a need to develop agreed exclusion criteria for conditions requiring medical review, therapy and monitoring that cannot be provided on Nauru, considering communicable diseases, chronic diseases, disability, developmental issues and other areas as needed.

k) **The lack of a formal Memorandum of Understanding with the RoN hospital –** noting the significant differences in facilities and clinical resources available between the IHMS clinical service and the hospital.

We note there are complex issues of equity across the Nauruan and RPC populations that extend beyond health services; these include vaccine schedules, education access, and food access.

Recommendations related to these issues are outlined in Section 5.

List of acronyms

AED	Automated External Defibrillators
AFP	Australian Federal Police
AHPRA	Australian Health Practitioner Medical Regulation Agency
ALS	Advanced Life Support
AMD	Area Medical Director
APLS	Advanced Paediatric Life Support
BBV	Blood Borne Viruses
BC	Blood Cultures
BCG	Bacillus Calmette Guerin (vaccine against tuberculosis)
BMP	Behaviour Management Plan
CAP	Claims Assistance Providers
CCM	Complex Case Meetings
CRP	C-Reactive Protein (marker for inflammation)
CSF	Cerebrospinal Fluid
CXR	Chest X-Ray
DIBP	Department of Immigration and Border Protection
DSM	Detention Services Manual
EAL	English as an Additional Language
FTE	Full Time Equivalent
GoN	Government of Nauru
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IAP	Individual Allowance Program
IHMS	International Health and Medical Services
IMP	Individual Management Plan
LTBI	Latent Tuberculosis Infection
MCH	Maternal and Child Health
MOU	Memorandum of Understanding
PSP	Psychological Support Plan
RoN	Republic of Nauru
RPC	Regional Processing Centre
RSD	Refugee Status Determination
SAF	Single Adult Female
SAM	Single Adult Male
SAMIS	Salvation Army Management Information System
STC	Save The Children
STTARS	Survivors of Torture and Trauma Assistance and Rehabilitation
STARTTS	Service for the Treatment and Rehabilitation of Torture and Trauma Survivors
TB	Tuberculosis
TIS	Translating and Interpreting Service
TSA	The Salvation Army
TST	Tuberculin Skin Test (used to determine exposure to *M. tuberculosis*)
UAM	Unaccompanied Minors
WWC	Working With Children

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2. Purpose

The purpose of the subcommittee visit was to provide assessment, commentary and recommendations on issues affecting the physical and mental health of people ('transferees') in held detention on Nauru.

The report has been prepared based on site visits and interviews with Department of Immigration and Border Protection (DIBP) staff, Nauru Regional Processing Centre (RPC) service provider staff, key stakeholder representatives, International Health Medical Services (IHMS) staff, people in held detention in each of the compounds, officials from the Government of Nauru, and Republic of Nauru hospital staff. We also were able to meet with members of the Nauruan judiciary and police force during a mental health information session.

3. Overview of context

3.1. Timing

The visit was 2.5 days in total, and occurred during a time of significant change. During our visit, news of the Manus Island riot became known, The Salvation Army (TSA) was in the process of handing over their case management and welfare responsibilities to Transfield and Save the Children (STC), the Refugee Status Determination (RSD) process commenced formally for people in RPC2 Alpha compound and RPC3, the first planned cohort of unaccompanied minors (UAMs) had arrived, the torture and trauma providers announced they were ending their contract, the medical director of the Republic of Nauru hospital was leaving to work in Kiribati, and a senior public health physician was transitioning out from his role as Secretary of the Nauru Health Department. In addition, the Nauruan judiciary had recently undergone changes, with particular impact on men in the Bravo compound.[a]

3.2. Local environment

3.2.1. General background

Background information on the Republic of Nauru is available.[1-4] Briefly:

- The land area is 21 km^2 and the majority of the Nauruan population live around the coast on a narrow coastal belt that is 200 – 400 m wide ('bottomside'). The interior of the island ('topside' or 'the pinnacles' - named for the remaining rocks) is the site of previous (primary) and current (secondary) phosphate mining and is the location of the RPC's three compounds.
- Climate – the mean temperature is 25 – 30 degrees, with an average of 80% humidity.
- The population of Nauru is approximately 10,000 people.[1] An additional 650 (non Nauruan) staff[b] and 1092 people in held detention (1742 people) is approximately a 17.5% increase in the population. If the RPC is scaled up to 3000 transferees, and staff numbers consequently increased, this would approximate to a 50% increase in the population on Nauru.

[a] Hearing dates had been adjourned until 4 March 2014 at the time of the visit.
[b] Total RPC staff numbers are 1300 on island at a given time, 53% are Nauruan.

- All land is privately owned in Nauru. The system of land ownership is complex, and land is commonly owned by large groups of individuals. These issues need to be factored into the planning, development, or extension of any structures or services.
- Drinking water supply is through desalination (four desalination plants) or collection of rainwater in household tanks in the local community. Most community houses have wells with access to shallow groundwater for washing and toilet flushing. Groundwater is contained in permeable limestone rock,[4] and is reported to be contaminated in 12 of the 14 districts.[c] Groundwater in the 'topside' area had previously been identified as a possible supply of high quality potable water.[4d]
- There are significant issues with waste (including medical waste), with potential for contamination of groundwater with an unlined waste disposal site, and sewage contamination of groundwater and seawater.[4] The Nauru National Sustainable Development Strategy 2005 – 2025 states "Waste management is minimal, including human, water, household and industrial".[3] Contamination from burial sites is also an identified issue.
- A significant amount of food is imported, and food supply has been extremely limited at times over recent decades during times of financial difficulty.

3.2.2. Health services in Nauru

Health services are provided by a single hospital, with 42-50 beds (the Republic of Nauru (RoN) hospital).[e] The RoN hospital has a two-bed emergency room, a two-bed high dependency unit, 12 acute adult beds, four acute paediatric beds, 16 long stay beds, two delivery rooms, six maternity beds, a single operating theatre, a room for patient overflow, and an additional renovated four-bed ward provided for the use of IHMS.[f] There is a separate outpatient clinic, a haemodialysis unit with 16 dialysis machines and a decompression chamber. A fire at the hospital in August 2013 resulted in loss of storage areas and the radiology, pharmacy and medical records departments. The Government of Nauru (GoN) are considering plans for rebuilding these facilities.

The hospital provides inpatient, outpatient, and midwife led maternity services. The hospital sees 60 – 130 outpatients daily, and delivers 360 babies annually, in addition to emergency and inpatient care. There is a well stocked pharmacy, with assistance for supply of medications through AusAid and vaccines provided by UNICEF funding, basic radiography and ultrasound facilities, and pathology services are available however are not comprehensive (see section 3.6.6). There is a single working adult ventilator, there are supplies of consumable equipment, and intravenous fluids are available.

There is no blood bank on Nauru. If a patient is in need of a transfusion in emergency situations, relatives donate blood and the patient is transfused after basic grouping, however there is no facility for antibody testing or blood borne virus screening.

There are eight medical staff in total employed at the RoN hospital - four general practitioners and four specialists - a paediatrician, obstetrician/gynaecologist, surgeon and anaesthetist. One of the

[c] Communication with Government of Nauru, Department of Health. The RoN hospital was formed in 1999 with the amalgamation of the Nauru General Hospital and the National Phosphate Corporation Hospital.
[d] The 2007 SOPAC report raised concerns about the refugee camp discharging effluent above the groundwater resource. At the time the refugee camp housed 70 people and 80 staff.
[e] Tour of the RoN hospital, and consultation with RoN staff, 18 February 2014.
[f] The IHMS ward is the only renovated ward in the hospital. Nauruan patients do not currently use this ward, which represents a significant inequity.

eight doctors is Nauruan. Visiting overseas specialists (in the fields of endocrinology, nephrology, ophthalmology, cardiology, psychiatry and visiting surgical teams including ENT and orthopaedics) are an additional source of medical care. Other staff include a pharmacist, a radiographer, and there are around 60 nursing staff, including 16 with midwifery experience. There are also dental and optometry services. Mental health services are nurse led, and provided from a single office, there is no specific inpatient facility.

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

3.2.3. Education in Nauru

There are three primary schools and two secondary schools (Nauru College for students aged 13 – 15 years, and Nauru Secondary College for students aged 16 – 18 years).[1] Class size is generally around 40 students, although student attendance is identified as an issue,[3,5] and year 12 enrolment is 32%.[5] The only school with land space for additional classrooms is Yaren primary school. There are no classrooms, furniture or resources at Nauruan schools to support additional children from the RPCs, aside from those involved in the current pilot program. There is a potential teacher shortage in the next two years, as teacher qualifications become mandated[h] by the GoN Education Bill by the end of 2014. This may result in the loss of up to 60% of current teachers. AusAID provide budgetary support for education, and relevant infrastructure.[6]

3.3. Regional Processing Centre demographics

On 17 February 2014 there were 1092 people[i] in held detention in Nauru, with facilities for 3200 people in held detention (RPC 3 = 1900, RPC 2 = 1300).[j] With the current population in held detention, there are around 1300 staff for the RPCs on island at any given time, 53% of staff are Nauruan.[k]

Statistics from early February 2014 were:[7]

- **Family compound (RPC3)** – 508 people, including 144 children aged 4-17 years, the most frequent country of origin was Iran and the second largest population group identified as being 'stateless'. Stakeholder staff reported a small proportion of people with family in

[g] Consultation with Government of Nauru Department of Health.
[h] Communication with Nauruan Operational Managers and Government of Nauru, Department of Home Affairs, Education, and Land Management.
[i] The difference between early February 2014 (n=1055) and the figure of 1092 people is due to an additional 37 people, including 10 unaccompanied minors arriving just prior to the visit. During the visit, staff reported that an additional 100 unaccompanied minors would arrive the following week.
[j] Communication DIBP staff, 17 February 2014.
[k] The RPC offers employment-based training for staff – Certificate 3 in Hospitality, Certificate 2 in Security.

Australia. People in RPC3 were aware of at least ten families where one parent was in Australia.

- **Unaccompanied minors**[l] **(RPC3) -** 10 unaccompanied minors (nine aged 17 years) arrived the day prior to our visit.
- **Single adult females (RPC3)** – 110 women, the most frequent countries of origin being Iran and Somalia.
- **Single adult men (RPC2)** – 437 men, the most frequent countries of origin being Pakistan, Iran, Afghanistan and Bangladesh and a significant proportion have identified as being stateless.

Information on duration of held detention was not available. This information is important in assisting us to make recommendations regarding health service delivery, as the relationship between length of time in detention and negative mental and physical health sequelae is well recognised.

3.4. Regional Processing Centre environment

The RPC was established over August – September 2012, the first service providers commenced work on 5 September 2012 and the first asylum seekers were transferred from Christmas Island on 14 September 2012.[8] Large parts of the initial RPC (what is now RPC1) were destroyed by fire after the riot on 19 July 2013. RPC2 and RPC3 have been under construction since 2013.

The current RPC consists of three main compounds:

3.4.1. Regional Processing Centre 1

RPC 1 includes stakeholder offices, operational centres, the catering centre, 'mess hall' (for staff) and main medical centre, managed accommodation (6 beds) [m] and supported accommodation sites (23 beds).[n] There is significant ongoing construction and heavy equipment on site at RPC 1 following the destruction of buildings during the riot on 19 July 2013. Part of this construction is the building of a two storey supported accommodation building which will contain 23 bedrooms. Most of the structures in RPC 1 are hard walled, and all hard walled structures have cooling. The external ground surface is white rocks, there is surrounding foliage. A checkpoint marks the entrance to the fenced compound.

IHMS facilities consist of a large suite of offices and consulting rooms and a clinic facility. They include: a large waiting, room, multiple offices, a two bed resuscitation area, a wing of mental health

[l] Age assessment is completed on Christmas Island under guidance from the 'Age determination' unit in Canberra. If Nauru DIBP or other stakeholder staff have concerns about the stated age of a minor there is a process to refer the matter back to Canberra.

[m] **Managed accommodation** is where clients deemed to be 'at risk' under a Psychological Support Plan (PSP), or those on a behaviour management plan can be accommodated, supported and monitored closely. There are 3 x 2 bed rooms, including internal bathrooms within a built structure, with cooling available. The rooms still include potential 'hanging points' due to the design of bed/bathroom dividers.

[n] **Supported accommodation** is where clients in need of more intensive medical care can be accommodated (examples include clients requiring antibiotics for a serious infection, or clients with temporary mobility issues such as crutches). Clients needing 'time out' can opt to be accommodated here for short periods. There are bed rooms containing bunk beds within a built structure, with cooling available. The new double story supported accommodation building (currently under construction) will have 23 beds.

consulting rooms, a wing of medical consulting rooms, a children's therapy room (with toys), a breastfeeding area, locked storerooms and medication storage areas, pathology collection, appropriately equipped vaccine storage areas, and separate rooms for Survivors of Torture and Trauma Assistance and Rehabilitation (STTARS) staff. IHMS also have access to a renovated a four-bed ward at the RoN hospital if required.

3.4.2. Regional Processing Centre 2

RPC 2 is divided into two compounds, 'Alpha' and 'Bravo', both for single adult males (aged 18 years and older).

Alpha compound includes a large general area and a separate area for males turning 18 years who are transitioned from RPC 2 to RPC 3 - termed 'vulnerable accommodation'. The Alpha compound is sited on the top of a hill, the ground surface is white stones, and there is no natural shade. There are some shade shelters available in the yard space. Accommodation is in large white tents, containing bunk beds spaced approximately 1m apart. There are approximately 40 people per tent. The mess hall/eating areas, recreation areas, and telephone areas are all in tents. There are hard walled bathroom and toilet facilities. There are electric fans available for cooling in each tent.

Bravo compound houses the single adult males who have been in long term detention and may face charges related to the riots on 19 July 2013. Bravo is similar to Alpha compound in terms of facilities, accommodation, lack of shade and ground surface, but is built in a hollow, and staff reported that consequently it is hotter.

The perimeter of both compounds is fenced, and there are entry checkpoints, muster points, and an IHMS tent at RPC2. There has recently been greater contact between the men in Alpha and Bravo.[o]

3.4.3. Regional Processing Centre 3

RPC 3 is separated into four compounds, for the following groups: families, unaccompanied minors, single adult females and a further area (not yet in use) intended for families with newborns up to four months of age. In the largest (family) compound accommodation is sited in a hollow, in large white tents, divided into multiple compartments (approximately 4m x 3m) by dark coloured plastic sheeting. There are 12 compartments in each section and the number of beds per compartment is determined by the family group size. Beds are stretchers with plastic coated mattresses. There are similar conditions in the tents for single adult females. Unaccompanied minors are accommodated in separate tents.

The tents for families with newborns are not currently in use – they have multiple semi-partitioned sections, with baby bath facilities at one end. We noted that there are no play spaces around the newborn/family tents.

The mess hall/eating areas, recreation areas, canteen and telephone areas are all in tents, with fans for cooling. The mess area has recently been doubled, moving the facility in order to deal with drainage issues in the original mess hall, which was having issues with flooding after rainfall. There is a large tent in the family compound for junior students school, divided by plywood partitions, some of which have been painted by people in held detention. There are only electric fans for cooling,

[o] The men were previously separated to a greater extent because of bail conditions after the 19 July 2013 riots.

these facilities were extremely hot. Children sit on the floor for lessons, furniture and educational resources appear to be very limited. Senior students attend school facilities in RPC 1.

Stakeholder staff reported there is a book library (with limited, predominantly English language books) and a 'toy library'. People in held detention and cultural advisors reported there are no books or toys available. One parent was deeply concerned that his child might take the toys from the child therapy room, as they were the only toys he had seen in several months. While inspecting RPC3, a couple returned a book to a TSA worker – it was titled *"A setback is a setup for a comeback"* by Willie Jolley. The TSA worker explained that this had been the only title available from the small collection of predominantly English language books.

There are 8 hard walled bathroom and toilet facilities, with separate facilities for males and females.

Pathways between tents are narrow, and ground surface is white gravel, with significant reflected heat and glare. There are multiple temporary fences across and between pathways, and multiple areas of construction around the compounds. The background noise of generators and construction is significant. There is a small amount of natural shade near the mess hall, but no natural shade around the tents.

There is a playground, which was not in use and not accessible at the time of our visit as construction had recently been completed. The playground is surrounded by a fence, and is in full sun for parts of the day. There is a volleyball court, and otherwise no play space for children.

The perimeter is fenced, and there are entry checkpoints, muster points, and an IHMS tent at RPC3 outside the main compound. Only the IHMS tent, tents for unaccompanied minors, and the (currently unused) tent facilities for families with newborns have air-conditioning available.

3.4.4. Other infrastructure details

Water - the water supply for people in held detention is obtained through desalination and delivered on site. Chlorination has recently been commenced. RPC staff currently drink bottled water. People in RPC reported the water supply is interrupted when the supply is changed, often occurring in the hottest part of the day.

Food is prepared at RPC 1 (for both staff and people in detention) and transported to RPC 2 and 3, where it is reheated and served. All food is shipped to Nauru. Volunteers from the population in the RPCs help clean up after meals. Snacks are available for children and pregnant women between meals. People are not able to take food back to their tents due to hot humid conditions and issues with deterioration/food safety. The quality of food provided was impressive with a high proportion of fresh vegetables and fruit.

Power – all power is from diesel generators, including power for water, sewage, and waste management. Back-up generators are available for the medical facilities at RPC 1.

Sewage and sewerage - each RPC has a sewage treatment facility, generating grade C effluent,[9] which is pumped onto the pinnacles. The disposal of the volume of effluent generated by almost 2400 people is a pressing concern. In the 2007 SOPAC report, there was concern at the impact of sewage on topside groundwater from the (then) 70 detainees and 80 staff.[4]

Waste – including medical waste, is disposed of at the local topside waste site. The RPC waste minimisation system[p] has not been working since the 19 July 2013 riots. The amount of waste generated by the RPC is identified as a very significant issue, including through use of bottled water by staff. There were no estimates of volume available. The medical incinerator at the RoN hospital has not been working for a significant length of time and medical waste, including blood contaminated waste, sharps and body parts is incinerated using diesel burning three times weekly in a separate section of the waste site. The waste site is not lined and is located on porous limestone. The risk of groundwater contamination appears to be significant.

Physical/mental health care - most physical and mental health care occurs at RPC 1, the IHMS tents at RPC 2 and 3 are used predominantly for dispensing medications, there is one examination bench in RPC2, most rooms contain only desks. They do not contain any examination couches/ benches. Resuscitation equipment backpacks are available at the IHMS tents located adjacent to the compounds, and a paediatric resuscitation backpack was reported to be available within RPC 3. See section 3.6.9 for process to access medical care.

Security – there are large numbers of security staff around and within the centres. We were informed that the majority have a military background. An incident report process is in place for reporting by welfare officers (part of security staff) who have concerns about individuals in held detention. Staff entering through the checkpoints to the RPCs need to complete an induction, sign in, store personal belongings/phones/computers, and wear duress alarms.

Transport between RPCs - RPC 2 and 3 are approximately 10 minutes drive from RPC 1 on an unsurfaced road that also accommodates heavy mining vehicles and thus can be in poor condition. The road has poor drainage after rain and sinkholes, slowing transit times. Transit between RPC 1 and the other compounds is required for delivering all food, accessing education and activities and for medical care

Activities - some activities are available outside the RPC for people in held detention – including swimming for children (2 sessions/day twice/week), volleyball for SAM (twice/week), and craft groups at RPC 1. There had been a single visit by a group of Nauruan women into RPC3 in 2013, to make grass skirts and flower garlands.[q] People in held detention (and cultural advisors) reported that they might be able to access one activity a week. Security assessments and community consultation are completed for all community-based activities.

Skills – a 'skills audit' has been completed in 2013[r] assessing the work experience and qualifications of people in detention. The results were not available for review, and are likely to be out of date due to movement/transfers of people, however we were told that there are doctors, teachers, midwives, cooks, mechanics and people with other professional and trade-based skills amongst the group in the RPCs.

[p] Information from Transfield management 18 February 2014- the waste minimisation system creates an 80% volume reduction and provides facility to sort waste – e.g. into paper, organic waste etc.

[q] The Nauru police reported this activity had been discussed widely in the community, and was viewed as positive. They reported the women were unable to make garlands, as the women in held detention were "*just grabbing the flowers and smelling them*". It was unclear why this activity had only occurred once.

[r] Meeting with DIBP staff, 17 February 2014.

Education - There has been a pilot program for 4 early high-school students at Nauru College and 11 late high-school students aged 16-18 years at Nauru Secondary College, with students attending with aides from STC. Primary school age children attend school for 4 hours a day within RPC3, other secondary school age children are transported to school facilities in in RPC 1. The curriculum is based on the Queensland education system, and support for English as an Additional Language (EAL) is available. There is no process for certification or recognition of achievement.[s]

Individual Allowance Program (IAP) system – adults are allocated 25 points a week, children get fewer points. People can accrue additional points through participation at education or structured activities, and for children, points are associated with school attendance. Points can be used at the 'canteen' to purchase a variety of items.

Clothing, linen, laundry – people are allocated two sets of clothes. Supply has been variable in the past, and many people reported they were embarrassed to only have a single set of clothing, and thus were not able to be clean in the hot humid environment. A number of Muslim women reported difficulty accessing covering clothing (long skirts, material to use as a hijab). Women are now able to access an adequate supply of sanitary products as required, rather than one at a time, which is an improvement on previous protocols.

Sheets and towels are changed once a week. Laundry is washed externally – there is a system to drop off and collect laundry – stakeholder staff reported frequent issues with items getting lost.

Smoking – the RPCs are non-smoking environments. Trading in cigarettes[t] is reported to be an issue.

Routine – a typical routine for people in held detention includes the following timelines – Breakfast 0700 (school children) then 0730-0900 for others, morning tea 1030 – 1130, lunch 1200 – 1400, afternoon tea 1530 – 1630, dinner 1830 – 2000. People typically have to queue for meals (30 minutes to 1 hour) and also queue for medications (often 1 hour). Children receive 4 hours schooling, and activities outside this time. People have access to phone calls once a week, and limited internet access for brief periods. People spoke of extreme difficulties sleeping due to the heat, and mosquitoes, exacerbating mental health issues.

Living conditions are extremely hot, humid, dusty and cramped. Background noise is considerable. People in held detention reported it was not possible to be inside tents after 10 am due to the heat, that the tents leaked with rain (wetting bedding), mosquitoes prevented sleep at night, and that there were spiders, rats and scorpions.

3.5. Stakeholders (non IHMS)

In addition to the two governments and IHMS, the principal stakeholders are Transfield, Wilson Security, Save the Children (STC), Survivors of Torture and Trauma Assistance and Rehabilitation (STTARS), interpreting staff from the Translation and Interpreting Service (TIS), and the Claims Assistance Providers (CAP). The Salvation Army (TSA) were ending their contract the week of our visit. Available information on data management systems and details on 'working with children' policies are provided below the relevant sections. IHMS is included separately due to the additional physical and mental health information.

[s] Meeting with DIBP staff, 17 February 2014.
[t] Between staff and people in held detention.

3.5.1. Transfield

Transfield provide garrison, welfare, maintenance, catering and site management. Security is subcontracted to Wilson and Sterling Security (forming Transfield security). Total staff numbers from end of November 2013 were:[u]

- 264 Transfield staff (228 male, 36 female)
- 560 Wilson Security staff (354 male, 206 female)
- 824 total staff (582 male, 242 female)

Transfield will be taking over the case management contract for men in RPC2 as TSA finishes, and the staff number will increase as they take on these welfare caseloads. Around ten staff working in case management have moved directly from TSA to Transfield.

Transfield use their own information management system, but are working with STC to develop a single shared record, although this is not yet defined, or in place.[v]

Transfield require Australian Federal Police (AFP) clearance for all 'ex-pat' personnel,[w] a Statutory Declaration from all personnel, and they have developed 'Practical working guidelines' for all personnel. Wilson Security staff also have the same requirements, although Wilson case management staff all have previous direct experience working with children.

All Transfield staff are provided with a three day induction after arriving on Nauru, including mental health and cultural awareness as part of their training. Wilson staff complete a similar induction in Brisbane.[x]

3.5.2. Save the Children

STC have provided education and case management for children since August 2013, and will move to case management for family units, and UAMs and SAFs in RPC2 as TSA finishes.[y] Total staff numbers from end of November 2013 were:[z] 39 staff (13 male and 26 female). It is anticipated new staff will work with adults in RPC2, and existing staff (with child experience) will continue to work with children and families. STC are looking to employ a paediatric nurse – clarification of this role and the interface with IHMS nursing expertise will be important.

STC currently use their own data management system – but are working with Transfield to develop a single shared record, although this is not yet defined, or in place.[aa]

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[u] Background briefing from DIBP 12 December 2013. These numbers are total staff, not staff 'on island' at a given time.

[v] Meeting Stakeholder management (Transfield, Wilson Security, STC) 18 February 2014.

[w] During the visit, we did not ascertain the proportion of Transfield staff from Australia.

[x] Pre-deployment training was previously delivered to Transfield and Wilson Security staff in Brisbane in March 2013, and TSA staff on Nauru received mental health awareness and Psychological Support Plan (PSP) training delivered by DIBP in March 2013.

[y] Meeting with STC management 18 February 2014.

[z] Background briefing from DIBP 12 December 2013, These numbers are total staff, not staff 'on island' at a given time.

[aa] Meeting Stakeholder management (Transfield, Wilson Security, STC) 18 February 2014.

STC conduct 2-3 reference checks, all applicants require a Working With Children (WWC) check, and have AFP clearance. All staff have some experience working with children, although the proportion with formal child qualifications was not available. Teachers are all Australian qualified with direct classroom experience, although the proportion with EAL training is not clear.

The STC manager holds delegated guardianship for all Unaccompanied Minors (UAM). Please refer to section 4.2.8 for further discussion on this issue.

3.5.3. Survivors of Torture and Trauma Assistance and Rehabilitation Service

STTARS provide torture and trauma focussed counselling, staff numbers from end of November 2013 were:[bb] 3 staff (1 manager and 2 counsellors).

Details of the working with children policies were not available at the time of writing.

STTARS announced that they were withdrawing their services from the Nauru RPC during our visit. We understand that the New South Wales Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) will take over their role.

3.5.4. Claims assistance providers

CAPs must have an AFP clearance certificate, and DIBP is considering an additional Statutory Declaration process, similar to that used by Transfield.

3.5.5. Interpreting staff

Interpreting staff provide assistance to DIBP, IHMS and other stakeholders as required.

Interpreters employed through the Australian Government Translation and Interpreting Services (TIS) must have an AFP clearance. TIS is currently considering introducing a WWC.

Stakeholder staff did not report any difficulties accessing interpreters.

3.5.6. The Salvation Army

The Salvation Army finished their contract on February 21 and were transitioning case management and welfare services to Transfield and Save the Children. Previous staff numbers from end of November were 99 staff (55 male and 44 female). TSA staff reported this process was occurring at management level in Sydney rather than by direct case based handover by staff based in the RPC. Around 30 people in held detention had not given permission for their case notes to be shared between TSA and Transfield, suggesting there was a consent process involving 'transferees'.

TSA previously used their own information management system (Salvation Army Management Information System 'SAMIS'), which was not linked with any other information system. They informed us that all case files would be provided to the new welfare provider if consent had been given for information sharing.

Previously, all TSA staff were required to have a WWC check or, if not possible, an AFP clearance certificate.

[bb] Background briefing from DIBP 12 December 2013. These numbers were staff at Nauru RPC at the time.

3.6. Stakeholders - International Health and Medical Services

IHMS are currently contracted to provide health services in the Nauru RPC. The standard of care is reportedly "*expected to be broadly comparable to the Australian community, and the best available in existing circumstances*."

All Australian IHMS staff are required to have a WWC Clearance.[cc] It is not clear what process exists for staff who are not Australian trained or registered.

3.6.1. Staffing

IHMS have 48.5 Full-Time Equivalent (FTE) staff on site. This number is far higher than the number of staff at the RoN at a given time. The staffing document is included as Appendix 1. On 14 February 2014 staff included (FTE shown in brackets):

- **Management/Administration**: Administration Manager (1.0), Nauruan Administration staff (4.0), Health Services Manager (1.0), IT Specialist (1.0), Logistics Officer (1.0), Quality Assurance Officer (0.5), Site Manager (1.0), Training officer (0.5)
- **Health**: Medical director (1.0, both physician in training level) General Practitioners (4.0, at least one with remote rural experience, mixture of males/females), Clinic Team Leaders (3.0), Primary Care Nurses (9.0), Paramedic/nurses (8.0 – *see following details*)
- **Mental health**: Mental health team leaders (3.0), psychiatrist (unfilled), psychologist (1.0) mental health nurses (4.0), counsellors (3.0)
- **Dental**: (0 FTE currently)

Other details:

- There are both male and female medical staff available
- Nursing staff are experienced, usually with five or more years practice. All nurses have Advanced Life Support (ALS) accreditation.
- Three nursing staff are registered midwives.
- There are two nurses who are immunisation accredited, and there is always an immunisation-accredited nurse on island. One of the clinical team leaders is Tuberculin Skin Test (TST) and Bacillus Calmette Guerin (BCG) accredited.
- Nursing FTE includes 1.0 FTE with Maternal and Child Health (MCH) experience.
- There is one nurse with a paramedic qualification, there are no stand alone paramedics.[dd]
- There is a single ambulance,[ee] used to transport unwell patients between RPC and from RPCs to RoN hospital. Staff identified that this vehicle is suitable for transport, but that it does not have adequate space to enable resuscitation during transport.

3.6.2. Paediatric experience

There are no paediatricians employed by IHMS, there are also no medical staff with neonatal or early childhood resuscitation experience, there are no staff (in any discipline) with Advanced Paediatric

[cc] Background briefing, DIBP 12 December 2013.

[dd] Members of the subcommittee received different information on paramedic staff, we would value clairification.

[ee] The ambulance is essentially a bush land rover – suitable for the roads between RPCs.

Life Support (APLS) training,[ff] although one staff member will undertake this course in the following months. There are no staff with child protection experience.

The psychiatrist position is to provide both adult and child psychiatry cover, and a child psychiatrist was due to start work the week after our visit. However, this individual is not in an ongoing role and thus it is not clear how this position will be filled. It was not clear whether the psychologists have paediatric qualifications. Nursing staff include 1.0 FTE MCH, an immunisation provider and three midwives, all of whom have paediatrics experience, although the duration and extent of experience was not available.

3.6.3. Maternity experience

There are 3 registered eligible midwives employed by IHMS. All were reported to have five or more years clinical experience. Nursing staff do not prescribe medications within the RPC.

The Detention Services Manual Antenatal care guideline[10] states that:

> *"Midwifery care is to be provided by an "eligible midwife" defined as one who is currently registered as a midwife in Australia and who is able to demonstrate the equivalent of three years full-time post-registration experience as a midwife and evidence of current competence to provide pregnancy, labour, birth and postnatal care through professional practice review. In addition they must have an approved qualification, or the ability to gain such a qualification within an 18 month period, to prescribe scheduled medicines required for practice across the continuum of care."*

It is unclear whether there are IHMS midwives with the ability to prescribe, although all nursing staff are reported to have five or more years clinical experience.

3.6.4. Registration and accreditation

All medical and nursing staff must be registered with the Nauruan health department. Australian staff are required to have registration with Australian Health Practitioner Medical Regulation Agency (AHPRA).[gg] Professionals from other countries need to be registered in their country of origin, and IHMS are contractually required to certify they have obtained qualifications of a similar standing to relevant Australian qualifications, and that they are capable of providing health care comparable to Australian standards.[hh] We were not able to identify criteria used to make these determinations by IHMS.

Not all health professionals are Australian trained or registered with AHPRA, although precise information on qualifications and registration was not available. All staff are covered by IHMS professional insurance.

3.6.5. Rosters

Nurses typically work six consecutive weeks with between two and six weeks off. Hours are typically 9.5 hours/day for six consecutive days. There are usually 8 – 10 nursing staff on day shifts, and 3 – 4

[ff] APLS is different to Advanced Life Support (ALS) training, which is adult focussed.
[gg] We have clarified that AHPRA have the powers to investigate a practitioner working offshore if notifications are made about their practice.
[hh] Background briefing from DIBP, 12 December 2013.

nurses on night shift. IHMS nursing staff do 'rounds' of the compounds three times daily to administer medication and to triage any people with health issues. Medical staff hours are 9.5 hrs/day, with staff on call overnight.

3.6.6. Facilities

Physical facilities are described in section 3.4.1.

IHMS has equipment for basic X-rays, and limited ultrasound. There is no capacity for obstetric ultrasound at the centre currently.[ii]

Pathology testing available at the RPC is limited to full blood count, electrolytes, C-reactive protein (CRP) liver function tests, lipid profile, glucose, venous blood gases and troponin. The RoN hospital can also perform these tests, as well as basic blood grouping, and urine and swab microscopy and culture.

There are no facilities on Nauru for other blood tests such as serology, blood cultures (BC), cerebrospinal fluid (CSF) cultures, or faecal studies. These tests are sent to Australia. Medical staff commented that the lack of blood culture facilities has led to empiric treatment and management and frequent use of broad-spectrum antibiotics.[jj]

Cold chain management at the RPC was appropriate, with impressive facilities at the IHMS clinic in RPC1, where vaccines are administered.

3.6.7. Clinical work - health

A significant proportion of IHMS clinical care is for stakeholder staff, including acute and chronic general practice, and care related to workplace injuries. Nauruan staff receive acute general practice care and care related to workplace injuries, but are referred back to Nauruan services for general care of chronic issues. Workplace injuries, including eye injuries, were identified as a significant part of workload.[kk]

Medical staff reported the most frequent conditions seen were: skin infections, ear infections including fungal external ear infections, allergic conjunctivitis, typically due to the combination of fans and the dusty environment, upper respiratory tract infections, thrush, pain (including back pain, exacerbated by the sleeping stretchers) and dental issues.

A women's health clinic including screening was run in the afternoons.

Medication dispensing – Two nurses dispense medications from the IHMS tents in the RPC2 and RPC3 compounds two or three times daily. People have to queue for their medications, often two or three times a day, and typically for 1 hour each time. There is a current trial of medication safes (n=20) although some medication types are not included in this trial (i.e. paracetamol, non steroidal anti-inflammatory drugs, and psychotropic medications). The current plan to is to expand this service for all people on medication, with the exception of those thought to be at risk of self-harm or where medications have a high risk of fatality in overdose.

[ii] There is a radiographer at the RoN hospital who can perform pregnancy morphological scanning, and the obstetric ultrasound has recently been replaced (lost in the 2013 fire).
[jj] IHMS medical staff, 17 February 2014.
[kk] IHMS staff, meeting 17 and 18 February 2014.

3.6.8. Clinical work – mental health

Mental health care is provided by the mental health staff within IHMS, and STTARS.

The main issues seen relate to a lack of certainty about when processing and RSD decisions will be handed down. Mental distress and uncertainty contribute to feelings of hopelessness and mental illness. Intrusive anxiety symptoms are prevalent – including constant worrying about the future, and anxiety about current living conditions, and how people are being treated - reinforcing a sense of insecurity, powerlessness and helplessness in everyday life.

There is a sleep management program in place, typically using counselling, in combination with short-term (3 days) use of benzodiazepines to reset sleep routine.

The number of people on psychotropic medications is recorded; in total there were 60 adults on psychotropic medications, representing approximately 6.3% of the adult population of the RPCs.

3.6.9. Referral process to IHMS

Each day IHMS receive 50-60 written requests for health care and a similar number for mental health care by people in held detention. These numbers do not include 'walk in' appointments (e.g. those triaged during medication rounds), emergencies or staff appointments.

Around 80% of written requests are in languages other than English. People complete a written request form at the security welfare stations in the compound. Requests in English are sent directly to IHMS, requests in other languages (where it is apparent they are for IHMS) are often checked by nurses on medication rounds, other requests are sent for translation (which may take some days) and then sent to IHMS.

IHMS book appointments and give the booking slips back to Transfield to give to clients.

Alternatively, people can give request slips to case management or welfare staff to bring to IHMS, or approach a nurse during the nursing rounds that occur three times daily.

IHMS medical staff see a total of 50 patients from held detention per day. The 'fail to attend' rate is 25 – 30%.

3.6.10. Referrals from IHMS to other services

Patients may be referred to the RoN hospital for acute clinical care for presentations that cannot be managed at the RPC. There have been very few referrals for acute care in recent months.[II] Referrals are also made for services that are not available through IHMS – including surgery, paediatrics, optometry and dental services. IHMS staff reported that the medical services most in demand are dental, optometry and paediatric and adult cardiology.

Referrals are sent to the RoN hospital, and a copy is also sent to the IHMS Head Office in Sydney. Outpatients are seen if there are resources available at the RoN hospital. Inpatients are admitted under Nauruan medical staff. IHMS provide additional nursing care, and bed sheets.

There are currently 240 people in held detention on the category 3 waiting list for dental care, many with significant oral health issues. There are no outstanding category 1 or 2 patients

[II] Meeting IHMS management staff, 17 February 2014.

There is no formal Memorandum of Understanding (MOU) in place for service provision in the RoN hospital for people in held detention or stakeholder staff. There is a draft MOU for provision of dental services using RoN facilities afterhours.

3.6.11. Medical evacuations and transfers

DIBP management on Nauru reported there was a well-established process for medical evacuations to Australia (typically to Queensland) with 12 - 18 hours between the evacuation call and transport availability, and rapid decision-making.[mm] Two transport services are used, costing approximately $85,000 per medical evacuation. Commercial flights are also used on occasion, following International Civic Aviation guidelines, and requiring 'fitness to fly' assessment, certificates and security. Management noted strong messaging was provided that the transfer to Australia was not permanent, and people would return to the RPC. Children requiring medical evacuation are accompanied by a parent.

The process includes a referral/clinical report that is sent to the Area Medical Director (AMD) then the First Assistant Secretary (FAS) for approval. The Chief Medical Officer for DIBP may also be consulted.

If all parties agree then approval is given for evacuation or transfer. We were informed this process usually works well, however there have been referrals where there has been a difference of opinion on the need for evacuation (typically where transfer is recommended for mental health reasons). It was not clear how such disputes are resolved, especially where the treating clinician has ongoing concerns about an individual's risk and condition.

Although management reported the time between evacuation and retrieval was 12 hours, clinical staff reported the shortest time between evacuation call and transport availability had been 14 hours, and that the usual time was 24 – 36 hours. Further details on evacuation numbers are provided in section 4.1.1 and 4.4.3.

3.6.12. Data management systems

Ten days prior to the visit, IHMS had transitioned to a new data management system 'Apollo' which handles bookings, medications, and clinical notes. They previously used 'Chiron' which is the same system used on Christmas Island, although the two Chiron systems were never linked. Records previously took 48 hours to be uploaded; Chiron files are still available as 'read only' documents. People arriving from Christmas Island have a USB that contains their medical information. Management reported the new system was a significant improvement; staff using the system reported significant problems, noting that the combination of a cloud based system and unreliable internet connection meant the new system was inaccessible at times and often very slow.

Access to other clinical resources (e.g. therapeutic guidelines or evidence based summaries) is also hampered by slow internet connection.

Chiron did not have research or federated data capabilities, so meta-data (e.g. proportion of people requiring immunisation catch-up or health screening) is still recorded on a system of excel spread sheets; representing an area of risk. The Apollo system was developed to address this problem

[mm] Meeting DIBP staff, 17 February 2014.

however the useability of the system may affect how clinicians input data. It was unclear how the existing system of excel spreadsheets would be aligned with the new Apollo system.

3.6.13. Critical incident reporting

The previous Chiron system contained an incident reporting system, and critical incidents are notified to the Area Medical Director (AMD). The new Apollo system was described as containing a number of flags, although we did not manage to see critical event reporting system within Apollo.

Self harm incidents and medical transfers/evacuations are reported to DIBP.

Medical staff reported they encouraged people to voice concerns, and that the most common issues identified were the quality of care and length of waiting times.

During the course of the visit we were not able to establish if there is a quality assurance framework.

3.6.14. Identified areas of need

IHMS staff identified the need for optometry/ophthalmology services, dental services, minor theatre facilities, a 'short stay' type ward area, an ambulance with improved resuscitation facilities, improved quality ultrasound and a mental health clubhouse/drop in room.

4. Areas of risk

4.1. Mental health, uncertainty and consequent risk

> *"It is not that we need treatment, it is the environment that is making us sick – if you change the environment we will be healthy." Men in RPC2 Alpha compound, February 2014*
>
> *"Life is so hard (here) there is nothing to do….Everyone just tells us to go back…they ask us about our suffering overseas, but not our suffering here." Couple in RPC3 compound, February 2014*

4.1.1. Self harm

There are critical issues with mental health, suicide and self-harming behaviours in people in held detention on Nauru.

Over the 14 month period 30/9/12 to 20/11/13 there were 102 incidents of self harm by people in held detention, including 28 attempted hangings/asphyxiations in 18 individuals, 5 people who cut their neck/throat, 9 people who had sewn their lips together, and other incidents including poly-pharmacy overdoses, cutting, and cigarette burns. Voluntary starvation is not included in recorded self-harm incidents. Three of these incidents required transfer to Australia. A further incident (self harm – stab wounds to abdomen and laceration to trachea requiring complex surgery) was not recorded in the self-harm database, but was recorded as a medical evacuation.[a] There appeared to be clustering of episodes in March 2013 (27 episodes) and the end of October to early December 2012 (30 episodes). Twelve people had made more than one self-harm attempt and ten of these had attempts that increased in severity and potential lethality. Nine people had made more than four self-harm attempts.

[a] Background briefing from DIBP 12 December 2013.

There were an additional 33 medical transfers or evacuations (24 transfers, 9 evacuations[b]) to Australia for psychiatric reasons, including seven evacuations for rehydration after voluntary starvation. These medical evacuations were all in adult males, occurring between 2 and 304 days after their transfer to the RPC (mean 142 days 11 transfers occurring after more than 220 days in held detention).[c] There was no information indicating that there have been self-harm incidents in children.

This average of seven self-harm events per month and two medical evacuations per months for psychiatric conditions needs exploration.

4.1.2. Communication and uncertainty

The majority of people in the RPCs are subject to the post 19 July 2013 policy aside from those in Bravo compound. They have been informed that they will not be allowed to settle in Australia. Cultural advisors indicated that on at least one occasion they have been informed they will also not be resettled in Nauru,[d] and noted: "*People have heard, but they don't believe it, it's their way of coping with the situation".*

Stakeholders were clear that they saw communication updates as the responsibility of the DIBP, and that they did not provide information on the RSD process to people in held detention. They stated people met with DIBP in the first four days after transfer, and that they were given clear messaging. It was unclear how ongoing information and updates were provided, and how this might be scheduled.

Many of the men in RPC2 Bravo compound have been in the Nauruan RPC for 18 months and RSD claims for this group commenced in January 2014. The men in RPC alpha compound and people in RPC3 have been there for up to 6 months or longer and RSD claims commenced in February 2014. The recent Review into the 19 July 2013 Incident at the Nauru processing centre notes: *"Transferees had been advised in March 2013 that their refugee status determination process would be completed within four to six months"*.[8]

The timelines of the RSD process remain unclear. The timeline to handing down a decision is not clear, and there is currently no review tribunal available.[e] It is not clear what has been communicated about the Nauruan judicial changes and the impact this will have on the RSD process, and it is not clear what has been communicated about long-term settlement in Nauru. This is contributing to considerable uncertainty.

People in held detention have a number of significant risk factors for adverse mental health outcomes, including past trauma and sometimes torture, family separations and loss, disruption of community, education and employment, prolonged uncertainty, a sense of being trapped, a lack of understanding or trust in the RSD process, and feelings of hopelessness.

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[b] Nine of the 12 medical evacuations over the period 23/11/12 to 29/11/13 were for psychiatric issues. Background briefing from DIBP 12 December 2013.

[c] Background briefing from DIBP 12 December 2013.

[d] This was an informal comment that was verified for accuracy. Retrospectively, it was extremely concerning in the context of the event on Manus Island that were unfolding during our visit.

[e] Meeting DIBP staff 17 February 2014.

We spoke with people in held detention individually and in focus groups. The majority of people felt trapped by their situation, they reported being told that 'they should go home' by various stakeholder staff, including health professionals, and were frustrated with this occurring and stated that they did not see this as being an option. They expressed difficulties living in the environment in the RPCs, and described the profound boredom, noise, heat, dust, leaking tents, mosquitoes, spiders and scorpions. They also expressed concern about the change in case management services and fears about what this might mean for them. Difficulties with telephone access were a major source of frustration – people appreciated that there was a mechanism to contact their families overseas, but described being devastated when they used most of their allocated 10 minutes trying to obtain a connection across the time differences, often unsuccessfully (meaning they had to wait another week).

The men in Bravo compound[f] expressed common themes of frustration and despair about being held in the compound and not being provided with information about the progress of their cases. Many believed the process was unjust and unfair and expressed distrust in the security staff following the riot. They stated that the individuals who had initiated the riot and started the fire were now residing in Australia and that they were being persecuted unfairly.

Similar themes of frustration, despair, and disbelief were also heard from the families and women in RPC3. Cultural advisors reported couples struggle to maintain relationships, and parents feel incapacitated in terms of parenting and looking after their children.

The combination of prolonged uncertainty, prolonged detention, delays in the RSD process, and issues with communication of or misunderstandings of key messages means that conditions are at significant risk of destabilising. There is a body of evidence on the unique risk factors for mental health problems in people in Australian immigration detention.[11-20] The offshore environment has a heightened risk due primarily to the lack of hope of ever being settled in Australia.

4.1.3. Mental health screening and case management

The DSM General health screening states[21]:

> *"Universal screening must be completed between 10 and 30 days of arrival. It is intended to establish a baseline mental health status for the individual and identify any mental health needs."*

With the current policy of 'rapid transfers' universal mental health screening therefore occurs after transfer. Although mental health staff reported 100% mental health screening,[g] we were not permitted to review case notes, and thus were not able to assess consistency of screening delivery, quality of outcomes or actions arising.

Service providers collaborate formally each day during PSP, Behaviour Management Plan (BMP) and Complex Case Management (CCM) meetings. Individual Management Plans (IMPs) are viewed as a strategy for service providers to collaborate to improve outcomes for people in held detention. Key stakeholders reported that collaboration has been good in recent months, although comments from

[f] Focus groups in Arabic, Farsi and Tamil languages. 18 February 2014.
[g] Consultation mental health staff, 17 February 2014.

a number of senior stakeholder staff indicated that there has been tension around case management roles.

We were not permitted to review PSP implementation or the appropriateness of risk classification**,** however only three people were on a Psychological Support Plan (PSP),[h] with staff reporting the number on a PSP ranged from 0 -15. This raises serious questions, given the number of self-harm events (average of seven per month) and number of medical evacuations for psychiatric conditions (average of two per month).

In order to minimise risk of mental health problems and self-harm it will be important to assess the sensitivity of induction mental health screening, to understand possible triggers, individual risk factors and vulnerabilities, and to assess staff training and understanding of PSP implementation and mental health issues. It will also be important to ascertain the quality and impact of mental health responses in order to reduce risk in this vulnerable population, and to monitor case management and welfare provision.

The need to understand mental health screening and service delivery is heightened with case management being transferred to a stakeholder without previous experience in the area. In conversations with senior stakeholder managers it was difficult for us to ascertain whether the key stakeholders have an adequate understanding of the complexities of this role. The current lack of shared record system, or single integrated vision for case management are concerning.

However, alongside any interventions in screening and case management, ultimately, the physical environment, lack of activity and options, delays in the RSD process and uncertainty are the greater risk factors for psychiatric morbidity and self-harm and potentially violence, and will require actions by all of the key stakeholders, including the Australian Government and the Government of Nauru.

4.1.4. Access to meaningful activity, education and local community engagement

Access to meaningful activity is an important factor in reducing adverse health outcomes. At other centres we have seen the benefits of activities that engage clients and provide them with a sense of purpose and meaningful engagement.

The current access to activity and education for adults is limited. Activities currently include volleyball for SAMs (twice/week), and craft groups at RPC 1, and swimming. There had been a single visit by a group of Nauruan women into RPC3 in 2013, to make grass skirts and flower garlands.[i] People in held detention (and cultural advisors) reported that they might be able to access one activity a week. Stakeholders reported plans to use the waste minimisation system and build garden beds to allow people to grow vegetables.[j] This is a positive initiative that has been effective at other centres with similar climates.

Stakeholder staff reported that activities were generally held when the Nauruan community was not using resources, and that there had been issues negotiating for the men in Bravo to leave the RPC

[h] Consultation mental health staff and IHMS staff, 17 February 2014.

[i] The Nauru police reported this activity had been discussed widely in the community, and was viewed as positive. They reported the women were unable to make garlands, as the women in held detention were "*just grabbing the flowers and smelling them*". It was unclear why this activity had only occurred once.

[j] Stakeholder management meeting 18 February 2014.

due to community concerns about risk. They reported that engagement with the local community was proceeding slowly, in a positive direction. The Nauruan operational managers outlined that extensive negotiation is required for any outing, including negotiation with community leaders, as all land is owned. They reported the community is still cautious after the July riots, although the local community perceives children and families more positively than SAMs.[k]

An additional factor in Nauruan community engagement was felt to be (negative) media reporting on Nauru – with the community being deeply concerned and offended about negative perceptions of Nauru, and disengaging from the people seen to be leading to the negative media reporting.

Minister Charmaine Scotty, responsible for Home Affairs, Education and Land Management and acting Minister for Health, noted that the local community have expressed that they don't know what's happening (in the RPC) and that there is significant secrecy about the people in held detention, and that people feel "*it's like they're not on the island*". There were similar comments by Nauru Police force and judiciary members. Both noted that the previous group of people in held detention over 2001 – 2007 were much more visible in the community, they were often in the shops, using the internet cafe and were described as friendly. Police also noted that the community felt people in held detention had better access to food and health care than the local community.[l]

Also see section 4.2.7 Education.

Engagement with the local community has potential for expansion and should be encouraged, for transferees mental health and to improve the local communities' knowledge and understanding of people in detention, and to reduce fear.

4.1.5. Criteria for transfer for mental health issues

In the absence of evidence to the contrary, we have presumed the process for transfer for mental health issues is the same as that for health issues (see section 3.6.11).

Clinicians highlighted some previous difficulties accessing approval for transfers for mental health issues. These difficulties appear to have been compounded by the related challenge of people's mental health presentations immediately improving with transfer from the environment driving their presentation (resulting in them being sent back to Nauru with consequent risks).

There is a need for independent oversight of this process if requests for medical transfer are declined and clinicians have ongoing concerns about people in held detention.

4.1.6. Local mental health legislation/code black policy

Under the Nauruan Mental Health Act, two health professionals need to 'recommend' that a client be managed involuntarily if there are concerns about risk of harm, and this needs to be approved after review by magistrate.

We note that IHMS does not have a 'code black' policy document to guide clinicians if they are in a situation in which a transferee is at risk of harm to self or others and cannot be managed by other

[k] Meetings Stakeholders and Nauruan Operations Managers, 17 February 2014.
[l] Mental information session Nauruan Police and judiciary staff, 18 February 2014.

means. IHMS staff reported they would call the Sydney office if they felt a client may need involuntarily sedation or physical restraint if no other option was available.

Neither strategy (judicial review or calling IHMS Sydney) would facilitate immediate management of an acute incident. Given the remote location of the RPCs a code black policy is required, to provide guidance on management of situations where people are an immediate risk to themselves or to others.

4.2. Child health

4.2.1. Child health screening

There are critical issues with the lack of health screening for children in held detention, including those transferred for offshore processing.

There are discrepancies between internal DIBP screening policies[22m] and IHMS procedures for children. We are aware of this through extensive clinical work in Australia with asylum seeker families,[n] and through previous and recent discussions with IHMS management in Australia and in Nauru. We were not permitted to review case notes, although people in held detention were clear that their children had never had blood testing or tuberculin skin tests (TST) while in detention. Stakeholder staff do not appear to be aware of this issue, and there are widespread misconceptions about the health screening completed in children.

The IHMS detention health check is analogous to the offshore visa health assessment,[23] and includes only a medical assessment (but no specific health screening) for children aged < 11 years. Chest X-rays (CXR) are completed for children 11 years and older; and blood tests are completed for children 15 years and older. The blood tests completed align with those suggested in the DIBP general screening protocol for those 18 and older (see below).[21] Effectively there is extremely limited screening for communicable/infectious diseases in children. The detention health check does not include an assessment of mental health, development or disability, unless the family raise concerns. Additional tuberculosis screening is only completed if there is a known history of exposure.

In comparison, general health screening and assessment for people aged 18 years and older includes blood tests for blood borne viruses (hepatitis B virus (HBV), hepatitis C virus (HCV), Human Immunodeficiency Virus (HIV)) and syphilis, and if clinically indicated, urinalysis including pregnancy test, finger prick blood sugar level (BSL), full blood examination (FBE) and liver function test (LFT).[21o]

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[m] Background briefing from DIBP 14 February 2014: Child health screening policies relating to communicable diseases, nutritional deficiencies and development were found in the child mental health section of the Detention Services Manual (DSM). Two of the Committee members were involved in drafting these protocols, but had not seen them referred to after February 2012, and were surprised to find them included in documents from the DSM. They have not been publicly available.

[n] We have not seen blood tests, or routine TB screening (using Tuberculin Skin Test (TST)) in any children from Christmas Island or any held detention that have arrived in Victoria. This includes direct care for many children and large triage sessions in Victoria for hundreds of people, where all IHMS documents and Health Discharge Assessments were reviewed.

[o] IHMS management reported blood tests were completed for people aged 15 years and older, which is in keeping with our clinical observations in Australia. The reasons for the discrepancies in the different reports of age for blood screening are not clear.

Although a recent internal audit "*considered the risk of a communicable disease not being detected in the IMA population as low*"[24] - if children are not screened, this statement is questionable.

Children in the RPCs should have had a detention health check performed on Christmas Island before transfer, although we were not permitted to review case notes during the visit and could not verify whether even this level of assessment had occurred.

It is important to note that in addition to the (offshore) visa health assessment, and also the departure health check for humanitarian entrants,[25] expert consensus and current Australian guidelines[26,27] suggest all asylum seekers and refugees, including children, should have a refugee health assessment (RHA) after arrival in Australia. The RHA includes identifying acute/chronic health issues, testing to detect nutritional deficiencies, communicable/infectious diseases (including tuberculosis (TB) screening, blood borne virus screening, parasite screening), mental health screening, developmental review and management of immunisation catch-up. The RHA is recommended due to the high prevalence of complex and chronic health and mental health issues in these children.

Evidence from paediatric and mixed child/adult refugee cohorts in Australia suggests the following prevalence figures:

- Anaemia in 10 – 20%, [28-32] with higher prevalence noted in young children (23 – 39%)[28,32]
- Iron deficiency in 11-34%[28-30,32,33] with higher prevalence in young children[28,32]
- Latent tuberculosis infection[p] (LTBI) in 20 – 55%, [29,31,32,34,35] across African, South Asian and Middle Eastern cohorts
- Active TB disease in 3.3% (note only one study)[36]
- Hepatitis B infection in 3 – 21%[29-34] in South Asian and African cohorts
- Schistosoma infection in 7 – 24%[29-35] in both African and South Asian cohorts, with higher prevalence in some African cohorts
- Strongyloides infection in 2- 21%[31,32,34,35,37] with higher prevalence in South Asian cohorts
- Malaria in 4 – 10%[33-35,38,39] predominantly in African cohorts.
- Pathogenic faecal parasites in 14 – 42%[30,32-34,37,39]

There are limited data on HCV, HIV infection or syphilis screening in refugee background children. There are limited data on mental health, developmental issues, visual or hearing impairment, oral health or disability, although refugee health clinicians in Australia report these issues are also prevalent. While the prevalence figures above are grouped by area of origin, children in held detention may have spent considerable time travelling to Australia, and may have infections/conditions acquired during their journeys in countries such as Malaysia and Indonesia. There are no data in this area.

Specific issues to highlight in relation to child refugee health screening include:

- Children with LTBI are at higher risk of developing active TB compared to adults, especially children < 5 years, and also adolescents.

[p] Latent TB Infection (LTBI) is evidence of tuberculosis infection (i.e. a positive screening test) without evidence of active disease based on history, examination, and CXR. Children with LTBI should be offered 6 months of preventive therapy to reduce their risk of developing active tuberculosis (TB) disease.

- Children with HBV usually have 'vertically acquired' infection from their mothers during pregnancy, although horizontal transmission (from child to child) is also important.[40,41] They typically have extremely high viral load for many years, meaning they are more infectious (e.g. in the event of a blood spill).
- Children are more prone to faecal oral transmission of pathogens, especially while in nappies or toilet training. Close living conditions will amplify the risk of any infectious conditions, particularly gastroenteritis.
- The early years are essential for long term developmental outcomes - surveillance and support are recommended for all children.
- During mid 2013, children were spending short periods in held detention, and the limited detention health screen was compensated for by the comprehensive RHA after release. However in the setting of prolonged detention there are strong clinical arguments to complete a detailed RHA for both individual care and public health. The prevalence of health issues in refugee cohorts justifies comprehensive screening; the RPC conditions and the duty of care are additional reasons for screening.

The lack of child health screening in detention health care (overall, and prior to transfer) means physical and mental health conditions are likely to emerge in children after transfer, and communicable diseases and developmental issues will remain unaddressed. The current policy on 48-hour turn around for transfer means pathology results are not likely to be available prior to transfer, even if health screening was implemented.

The child health screening process needs to be improved, it should be extended to include screening for acute/chronic health issues, testing to detect nutritional deficiencies, communicable/infectious diseases (TB screening, blood borne virus screening, parasite screening), and also include mental health screening, developmental review and management of immunisation catch-up. It should be regularly reviewed and subject to independent oversight. The DIBP guidelines for screening cover the relevant areas; we recommend they be implemented.

Ongoing surveillance - IHMS had draft protocols for ongoing child health checks, although these had not been implemented. The protocols were similar to 'well child checks' in Australian Child health records. IHMS had protocols for neonatal hearing screening (although it was not clear they had facility to test this), and for review at 1-4 weeks, 6-8 weeks, 6-9 months, 18-24 months, 3 years. Currently there is no ongoing surveillance for children. Background DIBP information states[q] "IHMS monitors all children on island for growth and development as well as dealing with health issues as they arise." There was no evidence that there are systems in place to monitor children's growth or development at present.

4.2.2. Immunisation catch-up (children and adults)

IHMS reported 80% had completed immunisation and an additional 20% had scheduled vaccine catch-up.

Full catch-up immunisation (to maximise immunity to vaccine preventable diseases) takes a minimum of 4 months. It is not possible to provide full catch-up immunisation to pregnant women,

[q] Background briefing from DIBP 12 December 2013.

as some vaccines cannot be given during pregnancy. The short duration of assessment prior to transfer means the majority of immunisation service delivery will need to occur post-transfer.

We asked people about immunisation in all compounds,[r] on a brief history, no one (adults or their children) had completed three sets of vaccines, suggesting no one was up to date.[s] Generally people reported they had a single set of vaccines on Christmas Island, and that they and their children had either not been vaccinated, or had only had a single set of vaccines on Nauru. Of note, delivery of immunisation within Australian detention system was problematic in early 2013 - two reports from asylum seeker triage sessions in Melbourne (811 and 327 people) found 56 – 60% of asylum seekers released from held detention had incomplete immunisation.[42,43]

We were not permitted to review case records, or the system of 'Immunisation master tracker' excel spreadsheets, so could not verify either report.

People living in close proximity present a real and ongoing risk for transmission of vaccine preventable diseases, especially where immunisation is incomplete. Outbreaks of rotavirus gastroenteritis, mumps, pertussis (whooping cough), rubella, measles, influenza or varicella (chicken-pox) are likely without adequate immunisation delivery. Hepatitis B is of concern - the combination of lack of screening in children, the high viral load seen in vertically acquired hepatitis B in children and the possibility of incomplete or unknown immunisation status present a risk of ongoing transmission.

The Nauru immunisation schedule[44] does not include the mumps, varicella, rotavirus, human papilloma virus or pneumococcal vaccines contained in the Australian Immunisation Schedule, conversely, the Australian schedule does not include BCG vaccine. The Government of Nauru requires school students to have BCG vaccine, which requires a TST first (the same test used for TB screening) – this had been implemented for the small pilot group of children attending the local school. Given the environment of the RPCs, the Australian immunisation schedule is preferable, although there is a strong case for BCG in addition,[t] and Hepatitis A, Typhoid, and influenza vaccines should also be considered.[45]

IHMS had sought Australian expert advice on immunisation, and had an immunisation schedule based on the Australian Immunisation schedule, also including hepatitis A for those aged over one year, BCG up to age five years, and typhoid for those aged over two years.[u] These additions are appropriate, although there is also a case for influenza vaccine[v] given the close living conditions. See section 4.7 on equity issues, including vaccine access.

[r] Focus groups with parents, families, and single adult females in RPC3.

[s] Full catch-up immunisation is recommended where there is no written record of previous immunisation. Almost no asylum seekers have written documentation of immunisation, and thus require at least three sets of vaccines over 4 months.

[t] For infants, children and adolescents who have not had BCG vaccination previously - BCG vaccine should be given to all infants and children up to 5 years of age after confirmation of a negative tuberculin skin test (TST), and considered in older children and adolescents. Ideally BCG should be given 3 months prior to travel. Administration of both TST and BCG requires specific training to administer intradermal injection.

[u] Immunisation protocols provided by IHMS, 19 February 2014.

[v] Influenza vaccine can be given from age 6 months onwards.

Staff vaccination policies appear to be appropriate and stakeholders request proof of vaccination and/or seroconversion prior to employment.[w] This positive initiative will help to reduce the transmission of vaccine preventable diseases between staff and people in held detention.

4.2.3. Child mental health screening

Details of child mental health screening[x] were unclear, and developmental screening was not in place. The DIBP Detention Service Manual Mental Health Policies for Minors in Immigration Detention[22] was actually a physical and developmental screening policy[y] and children are not mentioned in the Detention Health Manual under the Psychological Support Program.[46]

4.2.4. Child health services

Paediatric clinics are planned, but are not in operation at present. There is no routine developmental or well child check system in place currently. Children have been given priority in dental service access, and there were no outstanding category 1 or 2 dental referrals to RoN hospital dental services. Analgesia and pain management for children is likely to be an issue, with an example given of a child attending for their 3rd visit for dental extractions, the previous two visits had been curtailed because there was no analgesia available, and the child could not tolerate the procedure.

There are no IHMS paediatricians, there are no IHMS medical staff with neonatal, or paediatric resuscitation experience, there are no staff in any discipline with Advanced Paediatric Life Support (APLS) training.[z] There are no facilities for blood cultures, CSF cultures, and the evacuation time is reported to be between 24 – 36 hours, during which time an acutely unwell neonate or child would deteriorate and could die.

There is no MOU in place with the RoN hospital. There is a single paediatrician from Cuba with minimal English providing local paediatric services. The RoN hospital has a single working neonatal incubator and three infant warmers. There is an oxygen supply, and there is capacity to provide nasal prong oxygen, nasogastric feeds, gain intravenous access, and provide intravenous antibiotics, however there are no facilities for neonatal intubation or ventilation.[aa] We did not see bag and mask

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[w] Meeting with stakeholder management, 17 February 2014. Staff working with children are required to have the following vaccinations: influenza, Mumps-Measles-Rubella (MMR - if not immune), varicella (if not immune), pertussis (which only comes as a combination vaccine) and influenza. IHMS staff also reported staff are required to have Diphtheria-Tetanus-Pertussis and hepatitis B vaccines.

[x] Screening instruments or tools are designed to identify children and young people who have, or are at risk of, mental health problems and would benefit from a more thorough assessment. A more thorough assessment should be carried out by a child psychologist or child psychiatrist to identify the nature and scope of the mental health problem, make diagnoses where appropriate, and assess how distress is manifest, behavioural and emotional strengths and weaknesses,, developmental problems and adaptive skills. Other areas to be considered for assessment include social and family adjustment, cognitive development and education progress.

[y] Background briefing from DIBP 14 February 2014: Child health screening policies relating to communicable diseases, nutritional deficiencies and development were found in the child mental health section of the Detention Services Manual (DSM). Two of the Committee members were involved in drafting these protocols, but had not seen them referred to after February 2012, and were surprised to find them included in documents from the DSM. They have not been publicly available.

[z] APLS is different to Advanced Life Support (ALS) training, which is adult focussed.

[aa] Information provided in a background briefing from DIBP, 12 December 2013 stated that the RoN hospital had standard neonatal resuscitation equipment – the inability to provide neonatal ventilation would not be considered standard neonatal resuscitation practice in Australia.

ventilation facility, although it is possible this is available. It is unclear how resources are allocated if there is more than one sick baby.

The neonatal and infant mortality rates[bb] in Nauru are 26.8/1000 live births and 37.9/1000 live births respectively, which are both 8.9 times higher than the comparative values for Australia (3.0/1000 and 4.3/1000).[47] WHO data suggest one in 37 babies dies during the neonatal period in Nauru.[47] Understanding the reasons for these disparities would help inform recommendations to reduce risk for children in the RPCs and Nauruan children.

From a medical care perspective, there are significant risks in this environment for children. The standard is not in keeping with an Australian community standard of care, including the standard for remote or regional Australia. The standard is not adequate for children of asylum seeker/refugee background who carry significant vulnerabilities and who essentially have no screening prior to transfer. There is also an ethical argument to address disparities and improve services for Nauruan children.

4.2.5. Child mental health services

The psychiatrist position provides both adult and child psychiatry cover, and a child psychiatrist was due to start work the week after our visit. It was not clear whether the psychologists have paediatric qualifications, and whether mental health nurses have paediatric qualifications or experience.

4.2.6. Criteria for exclusion / transfer in children

There were no criteria for excluding transfer or transferring children identified, although IHMS staff reported they would not accept transfer of children (or people) with disability. No transfers of children were recorded. Of note, adults have been transferred off Nauru for blood borne viruses (BBV), whereas children are not screened for BBV.

4.2.7. Education for children

Education is an essential part of child wellbeing, development, and learning and is a pathway to becoming a productive and successful adult.

All children in the RPCs access school. Primary school age children have four hours of schooling on weekdays, which does not include recreational activities. Secondary level children are transported school at RPC1. Conditions are described in section 3.4.3; they are not conducive to quality education, and students receive fewer hours than either Nauruan or Australian education systems.

Nauruan schools are described in Section 2.2.3. There is no capacity for additional students in Nauruan schools currently, we were advised the only school with land available for additional classrooms is Yaren Primary School, and there will also be a significant teacher shortage within the next 1-2 years. It is not clear how education might be provided outside the RPCs in the current environment.

The pilot program of RPC students attending Nauruan schools was regarded as a positive initiative by DIBP staff, stakeholder management, Nauruan Operational Managers and Government of Nauru

[bb] The neonatal mortality rate is deaths in the first 28 days per 1000 live births; the infant mortality rate is deaths in the first 12 months per 1000 live births.

representatives. Stakeholder staff reported improved mental health and wellbeing in children in the pilot programs, and also reported improved wellbeing in children who were simply able to access school facilities over the preceding Christmas holiday period.[cc]

4.2.8. Child protection

Child protection issues are a major concern. Detention, and the grouping of large numbers of children and adults in crowded living conditions, without normal social structures or activities, risks exposing children to physical and mental violence, and places them at significant risk of sexual abuse. Unaccompanied minors have specific risk and vulnerability,[48] [49] and are reported to be at particular risk of mental health issues and sexual violence.

There is no clear child protection framework for children in the RPCs. There are no stakeholder or IHMS staff with child protection experience. Stakeholder agencies have measures to perform Australian police and working with children checks when employing Australian staff, however it is unclear what checks are undertaken for Nauruan staff, or staff from other countries. No stakeholders had child protection policies in place. Stakeholders suggested they would refer to the Nauru police in the event of child protection issues.

Guardianship of unaccompanied minors in the RPCs is delegated to the manager of Save the Children. On discussion with senior management it was unclear how decision-making or acting in 'best interests' might occur, what legal training had been undertaken, which legal framework would be utilised, whether the organisation had protocols for management and decision making in sentinel events (e.g. sexual assault) and whether there was a plan for long-term review and support of children's rights.

Nauru does not have a child protection framework, although we understand there is consideration of a child protection policy developed in Kiribati with AusAid support. This is an important and timely consideration that should be expedited in the context of children and UAMs being accommodated in the RPC.

Nauru police have a well-established family violence unit, although police reported child protection issues would be challenging and unfamiliar work. The child protection experience of the non-English speaking local paediatrician from Cuba is unknown, but there would presumably be language discordance. There was no clear ability to provide a forensic chain of evidence should the need arise.

Child protection issues are unresolved, and present a significant risk to children.

4.2.9. Facilities for children

The RPC is not a suitable environment for children. Physical conditions are harsh, with noise, dust, heat and humidity. Parents reported that thongs wore out almost immediately on the gravel, and children reported pain walking and running within the centre. Many parents in RPC3 commented the water supply was typically changed during the hottest part of the day interrupting the availability of drinking water for up to 2 hours and particularly affecting children. They asked for this to be done at a different time of day. There are inadequate school facilities, and inadequate play spaces. There are concerns about child protection issues, and they are likely to be exposed to others' mental health

[cc] RPC schooling was moved to Nauruan school classrooms over the holiday period while Nauruan students were not using the facilities.

issues and self-harming behaviour. There are children who are separated from one of their parents in Australia. There are no toys, including no soccer or volleyballs; parents reported

> *"All they can play with is the white stones and running, there is nothing to do"*[dd]

Excursions are limited, they do not have freedom of movement, and so are not able to engage or play in the natural environment.

Crowded living conditions are of significant concern from a public health perspective, particularly if there are concerns over sanitation and water, and where individuals have not had adequate health screening or vaccination.

Children are particularly vulnerable to the negative consequences of detention on mental health[14,16,19,50] and detention adversely affects families and parenting.[11,19] Many children will have been exposed to cumulative risk factors in their countries of origin and during their migration journey, and will have physical and mental health sequelae making them more vulnerable to the effects of detention. The length of detention is an additive factor.

Children are likely to have adverse developmental and mental health outcomes, but as there is currently no developmental surveillance, it will not be possible to quantify the impact.

4.3. Maternal health and obstetric services

There are currently 15 women known to be pregnant in RPC3, with another five who have been transferred for care in Australia due to the development of complications or being over 30 weeks gestation.[ee]

4.3.1. Antenatal screening

DSM antenatal care guidelines are available.[10] They are based on Australian antenatal care guidelines, although they list the 18-20 week pregnancy ultrasound as optional.

All women are screened with the Edinburgh postnatal depression scale, which is also validated for use during pregnancy in different cultural groups.[51,52] Mental health staff reported consistently high scores on this scale for the majority of women screened. Most women scored around 24, where the cut point for detecting significant depression is 10.

We were not permitted to review clinical files of pregnant women to assess the quality of screening and care being provided.

4.3.2. Access to services

Details of RoN maternity and neonatal facilities are in section 3.2.2 and details of neonatal resuscitation experience are in section 3.6.2.

RoN hospital maternity services are midwife-led. An obstetrician from Papua New Guinea had recently commenced work in Nauru, but left shortly after our visit. There is no obstetrician on Nauru currently. World Health Organization (WHO) 2007 data found that only 40% of pregnant women in Nauru attended at least four antenatal visits.[47]

[dd] Families in RPC3, 17 February 2014.
[ee] Background briefing information DIBP 14 February 2014.

The RoN has some resources for management of pregnancy complications including syntocinon and Rhesus anti-D, although there is no blood bank. Caesarean deliveries are possible, although women with complicated pregnancies may be transferred overseas, including to Australia, for medical care. The outgoing Secretary of Health reported there had been two transfers for obstetric complications in the previous year.[ff]

According to WHO data, the maternal mortality ratio[gg] in Nauru is 300/100,000 live births which is 35.7 times higher than the comparative value for Australia (8.4/100,000).[47] One woman dies per 333 live births in Nauru and given current birth rates approximates to one death per annum. Further understanding of the reasons for this disparity may help to reduce risks. Hospital staff reported that post-partum haemorrhage is one of the most common reasons for maternal morbidity and mortality.

4.3.3. Criteria for exclusion/transfer during pregnancy

The DSM antenatal care guidelines[10] currently state:

> *"Pregnant women should be routinely transferred from remote centres to give birth at 32-34 weeks gestation."*

To date all pregnant women in the RPC had been transferred to Australia for routine ultrasounds as obstetric ultrasound had not been available in Nauru until recently (the hospital ultrasound machine was lost in the fire in August 2013). There is now an appropriate ultrasound at the RoN hospital and the RoN radiographer is reported to be skilled in obstetric ultrasound.

Currently women thought to have high risk pregnancies on IHMS assessment are transferred to Australia to deliver. Partners are able to be at the delivery, but may travel separately.[hh] Nauruan women with complicated transfers may also be transferred for care overseas (as above).

Cultural advisors indicated that people in the RPCs are aware pregnant women are transferred for care in Australia, and that women see pregnancy as a way of being transferred out of the RPC. There is potential for an increased number of pregnancies, and women will need to be informed of the reality and the risks.

4.4. Service efficiency and access

4.4.1. Client consent procedures

Client consent is required for sharing of health information, as outlined in the DSM General health assessment.[21] Some people in held detention stated that they had not been asked to provide informed consent to share their health information. Conversely, IHMS reported 30 men had not given consent to share information with the change in case management, suggesting there was process in place to record consent given. Further information about the consent process on both Christmas Island and in Nauru will be important.

[ff] Communication, Secretary for Health, Government of Nauru 19 February, 2014.
[gg] Maternal mortality ratio is maternal deaths per 100,000 live births.
[hh] Information DIBP staff, 17 February 2014.

4.4.2. Appointments and access to services

Also see section 3.6.9 for the process for people to request IHMS review.

People in both RPC2 and RPC3 identified issues accessing IHMS care, and there were striking similarities between the reports from both compounds. People reported they "*wait too long*" for IHMS, and that they typically submit multiple requests, often four or five, before they receive an appointment, and wait many days before they receive an appointment. A number of individuals reported they had received appointment slips after their appointment time. Further, their perception was that when they were seen, the consultations were not useful, and that "*They just give you water and panadol*". Many people reported they had health issues and wanted medical review, notably for dental issues, but some for more concerning physical symptoms. Several people reported they had been waiting weeks to months for spectacles.

Both SAF in RPC3 and SAM in RPC2 stated they did not report mental health issues to IHMS, and, in reference to case managers and welfare staff the SAM reported: "*They visit, but they don't listen"*.

IHMS management reported it can take up to 10 – 15 days to get a request for medical care translated, which would be in keeping with people waiting prolonged periods for review. There is a separation between interpreting services (who are on site and could presumably read the request out in order to facilitate bookings) and the more formal translation services, which take days.[ii]

The IHMS 'fail to attend' rate is 25 – 30% for medical appointments, also suggesting there are significant issues with the bookings and appointments process. The current system does not appear adequate to cope with the needs of the population. This process needs to be streamlined to avoid long wait times that could potentially place individuals at risk.

4.4.3. Medical transfers and evacuations

Over the 12 months between 23/11/2012 and 29/11/13 there were 53 medical transfers or evacuations (41 transfers, 12 evacuations) - 24 transfers for mental health issues, nine evacuations were for mental health issues. There were 17 transfers for medical issues (including 3 family members transferred to be with a pregnant woman) and 3 medical evacuations. Of 14 clients transferred for medical management, conditions included appendicitis, kidney stones, periorbital cellulitis, eye disease, chest pain, urology issues, gynaecological cancer and obstetric complications. The five transfers for pregnancy related reasons noted in section 4.3.3 all occurred after this reporting period.

4.4.4. Emergency management

IHMS at RPC1 is well equipped with resources to manage adult emergency situations, and equipment is available for all ages. Full adult and paediatric resuscitation kits are available in the IHMS tents and clinic at each RPC and there are Automated External Defibrillators (AED) in each compound that are readily accessible. Transfield and Wilson security staff reported that many had first aid training, although first aid training was not a routine part of their induction and training in use of the AEDs was also not compulsory. IHMS staff are not always available within the accommodation compounds.

[ii] Interpreting is listening and speaking from one language to another, translation is reading and writing from one language to another.

All staff in the RPCs should be familiar with basic CPR and the use of AEDs in case of a medical emergency. There have been a number of cardiac arrests in young people across the detention network. The chance of surviving a cardiac arrest is improved by rapid response and use of defibrillation as appropriate. The risk of non-medically trained people using AEDs is minimal; they are designed to be used in community situations, AEDs will not shock unless it is appropriate and they provide clear, easy to follow instructions.

4.4.5. Dental service access

There are currently over 240 people on the category 3 waitlist for dental services, individuals with a category 1 or 2 rating on the dental triage system as 1 and 2 to date had been seen by the dentist at the RoN hospital. There is currently a plan for a IHMS contracted dentist to use the dental facilities at the RoN hospital outside normal clinic hours and on the weekends to reduce the numbers waiting, with a draft MOU around this. The local Nauru waiting lists for dental services are unknown, but this would be important to clarify.

4.5. Public health

4.5.1. Blood borne viruses

Following the commencement of rapid processing with a '48 hour turnaround' between arrival on Christmas Island and to transfer to RPCs we understand pathology results from the Health Induction Assessment/General Health Screen have generally not been available prior to transfer.

This policy has meant that people with blood borne virus (BBV) infection have arrived in Nauru before their positive BBV status was known. To date IHMS reported 15 people have been transferred back to the Australia due to these circumstances,[jj] although DIBP documentation recorded three transfers over the period 8/9/13 – 1/12/13, and these cases were not included in the medical transfers/evacuation reporting system.[kk] We understand this relates to the details of the MOU in place with the GoN, in which case it is important to clarify misconceptions around health screening in children. As children are not screened for BBV currently, it is likely there are children with BBVs on Nauru. Please refer to section 4.2.1 for available data on prevalence of infection in children.

There are additional risk management considerations if people become aware that blood borne virus infection may lead to transfer to Australia.

We were informed that condoms are available from containers at Transfield muster points. The availability of barrier protection to reduce risks of sexually transmitted infections is important. At other centres we are aware of the high rates of MSM activity. Condoms should be readily available in discrete locations without the need to interact with staff.

4.5.2. Dengue virus

Dengue is an arboviral[ll] disease complex caused by four serotypes of dengue virus. A dengue virus infection may be asymptomatic or it may lead to undifferentiated viral fever syndrome, dengue fever (DF), dengue haemorrhagic fever (DHF), or dengue shock syndrome (DSS).

[jj] Communication, IHMS staff, 18 February 2014.
[kk] Background briefing, DIBP, 12 December 2013, transfer statistics also supplied during the same briefing.
[ll] Arboviral infections are infections that are transmitted by mosquitoes.

Published information[53] notes the lack of surveillance data on Dengue in Nauru in recent years, although there was an outbreak in 2003, [mm] and both mosquito vectors *Aedes aegypti* and *Aedes albopictus* are found on Nauru. However, the Government of Nauru Department of Health indicated there have been 20 – 30 cases of type 1 and type 2 Dengue fever over 2009 – 2010, although the majority of these diagnoses had been made clinically and were not confirmed by serological testing. There had been fewer cases since this time, although cases were reported every year for the preceding five years and there have been four cases of locally acquired haemorrhagic dengue in 2013, some with serological confirmation.[nn] Frequent flights from Fiji (endemic for dengue, with high prevalence currently) are a possible pathway for Dengue recurring in Nauru.

This is an issue of significant concern that needs clarification, and if confirmed, will require active management. DHF has a high mortality rate, ranging from 1 – 20% depending on the specialised medical care available. The combination of mosquito vector, open tent accommodation, high recent rainfall with poor drainage and multiple areas of surface water, and high population density creates conditions for a dengue outbreak. We suggest review of the communication pathways between the Nauruan Department of Health, Centers for Disease Control, the DIBP and IHMS.

Key management measures will be establishing mosquito surveillance and improving mosquito control, establishing case surveillance (i.e. through regional CDC surveillance and notification) and having ready access to management guidelines.

Currently, the only methods for preventing and controlling DF/DHF are to:[54]

- Ensure prompt diagnosis of fever cases and appropriate clinical management
- Reduce human-vector contact through environmental management, personal protective measures (e.g. repellents or insecticide treated bed nets) and health education
- Control vectors and larval habitats in and around domestic environments, e.g. by physical and/or chemical measures

Mosquito fogging occurs on a regular basis at each RPC site, however RPC 2 is more difficult as the external perimeter fence is inaccessible in some parts due to a steep incline.[oo]

4.5.3. Tuberculosis

Tuberculosis is classified by IHMS as being a 'moderate risk' for outbreak,[pp] however this is based on the premise that '*screening on arrival prevents transfer of transferees with tuberculosis*'.

As described in 5.2.1 - children aged younger 11 years are not screened for tuberculosis exposure or disease and the 'rapid turnaround' policy means people are transferred without their screening test results or formal CXR reports being available. Australian onshore refugee health screening guidelines recommend screening for tuberculosis exposure, in order to detect and treat active tuberculosis disease missed in offshore screening, and also to detect and manage latent tuberculosis infection,

[mm] This outbreak occurred during operation of the previous RPC – at the peak there were up to 90 presentations daily to the RoN hospital and people in detention and staff at the RPC were also affected.
[nn] After receiving this information we notified site management and IHMS.
[oo] Information from Transfield management, meeting with Stakeholder management, 18 February 2014.
[pp] Background briefing from DIBP 14 December 2013.

which carries a lifetime risk of reactivation (to active TB disease) of around 10%. The risk of progression/reactivation is higher in young children, especially those < five years.

The Government of Nauru Department of Health noted there had been at least one recent contact for active pulmonary TB[qq] transferred prior to this being recognised, which was a source of concern for local authorities.

We were not permitted to access the 'master tracker' tuberculosis excel spreadsheet or review clinical files to ascertain the quality of TB screening, contact tracing or management. Independent oversight of this process is important, as the public health ramifications are significant.

In Australia, Communicable Disease Control (CDC) coordinates contact tracing and oversees management of individuals with suspected TB. The communication pathways between the Darwin CDC office, IHMS and the Nauruan Department of Health are unclear, and clarification would be helpful.

4.5.4. Other communicable diseases

Close living conditions amplify the risk of disease transmission and there is a risk of vaccine preventable diseases, gastroenteritis, and water borne diseases. There is currently no parasite screening for people in held detention, although parasite infections, including *Giardia* and *Strongyloides stercoralis* are common in refugee cohorts,[30,32-34,37,39] and transmission is a risk where there are sanitation concerns.

4.5.5. Medical isolation & outbreak management planning

There are designated tents in each compound for medical isolation purposes. IHMS staff were able to explain how these tents would be used in the event of a communicable disease outbreak. During a recent gastroenteritis outbreak, IHMS referred transferees to the RoN hospital where a ward was designated for triage and management. We were informed this ran smoothly. This is a further reason for establishing an MOU with RoN hospital to ensure that resources are shared in the event of an outbreak.

Nonetheless crowded living conditions and the environment of the RPC mean outbreaks of communicable diseases are likely to continue occurring in the future. Ensuring vaccination completion (for transferees and staff), education about hand washing, access to hand sanitisers, mosquito control and surveillance (as outlined in section 4.5.2) are important measures to minimise risk.

4.6. General health service provision

4.6.1. Registration of health professionals/complaint management

Please refer to section 3.6.4.

[qq] Pulmonary (and laryngeal) tuberculosis are considered infectious to others through droplet spread. Children are often not infectious, even with pulmonary TB due to different patterns of disease and reduced coughing force compared to adults. Pulmonary TB accounts for around 80% of all TB cases in Australia, although overseas born cases are more likely to have extra-pulmonary TB disease (in other sites).

IHMS management reported that if concerns arose about an individual's clinical practice, this would be managed within IHMS. A structure of external oversight when notifications are made about a professionals practice is important to ensure safe and quality provision of care. This is typically achieved through the registration agency (such as AHPRA) or an Ombudsman.

4.6.2. Pathology access

Please refer to section 3.6.6.

There are risks associated with needing to transfer more complex pathology to Australia to be processed, particularly blood and CSF cultures where results are often needed as soon as possible to improve clinical outcomes.

4.6.3. Memorandum of understanding with the Republic of Nauru Hospital

There is no formal MOU in place with the RoN hospital, although the hospital provides back-up for complex cases from the RPCs across all areas. To put this in perspective, a hospital with around 20-30 staff on a given day that serves a local population of 10,000 people is providing backup to a health centre with around 50 staff on a given day, that provides health care to 2300 people. It is unclear how use of the RoN hospital by people from the RPC affects local access to care, including to resources such as neonatal care, dental care and optometry services.

There are substantial risks associated with not having a formal MOU in place with the Nauruan health services. These risks include:

- Inequitable sharing of resources with adverse clinical outcomes for local community and/or people in held detention
- A lack of clarity about how care is prioritised, particularly with access to outpatient clinics
- Negative impact on local community access
- Negative impact on some types of care provided to transferees (e.g. dental care)
- Potential issues with communication around notifiable disease outbreaks (with possible impact on surveillance and management of such outbreaks).
- Lack of planning for mass casualties or outbreak-related conditions
- Lack of clarity around management of child protection
- Lack of clarity around management of domestic violence cases.

4.7. Equity issues

There are significant equity issues to consider in long term planning, notably in the areas of food access, health care, and vaccines.

The quality of food provided at the RPCs is excellent, and both RPC staff and members of the Nauruan police noted that it contains a wider variety and a greater proportion of fresh food compared to the local diet. RPC staff, including local Nauruan staff, eat at RPC 1 during their work hours.

The difference between IHMS facilities and the RoN hospital is stark. Please see sections 3.2.2 and 3.6.6. Conditions at the RoN hospital are difficult, whereas IHMS has impressive facilities, stock and staffing. There is no formal MOU in place with the RoN hospital, as above. It is unclear how use of the RoN hospital by people from the RPC affects local access to care, including to resources such as

neonatal care, dental care and optometry services. We also note differential access to IHMS care between local Nauruan staff, and stakeholder staff.

In the longer term, IHMS facilities likely represent a health care resource for Nauru, although they do not currently include all the facilities of a hospital. The RoN hospital requires significant redevelopment. Priorities identified by RoN staff were rebuilding the hospital, nurse training particularly in infection control, operating theatre nursing, and paediatric nursing), and the paucity of allied health and pharmacy staff. Another issue identified as critical is the future health workforce across all health disciplines, particularly the need for access to education and mentoring for local students to improve retention in and completion of post-graduate degrees.[rr]

There are differences in vaccination schedules for Nauru and Australia; also raining issues of equity I vaccine access. The Nauru immunisation schedule[44] does not include the mumps, varicella, rotavirus, human papilloma virus or pneumococcal vaccines contained in the Australian Immunisation Schedule, conversely, the Australian schedule does not include BCG vaccine. There is a strong ethical argument to make the same vaccines available for both children in detention and Nauruan children, and aiming for the more comprehensive coverage provided by the Australian schedule, in addition to BCG vaccine, which is appropriate. Regular sharing of information between IHMS, DIBP and the GoN Health department will be important to improve planning, reduce these inequities, and consequently improve health outcomes.

Education is a further area of concern. Children in the RPCs have access to schooling and qualified teachers, although the physical conditions (stifling hot, enclosed tents with limited facilities) and amount of schooling (4 hrs/day) are not conducive to learning. Positive benefits are reported for children attending school outside the RPC with access to play areas.

The Nauruan Government also identifies education as a priority area, noting issues with teacher qualifications, student retention (especially in secondary school), student attendance, and outcomes.[3,6] Our understanding is that there are currently neither facilities nor additional land to support combined schooling beyond the pilot program. Clearly there are space constraints currently which are not easily overcome, however the likely upcoming shortage of teachers in the Nauruan education system may be ameliorated by the presence of qualified STC teachers. Resource sharing might be a possible path to supporting Nauruan education and improving engagement between the RPCs and the community.

4.8. Engagement with local community

Also see section 4.1.4: Access to meaningful activity, education and local community engagement

Communication with local community – around 650 RPC staff are Nauruan, creating a pathway for information about the RPC to pass back to the Nauruan community. An 'RPC newsletter' was used in mid-2013, but had ceased. Community consultation occurs before activities in the community.

Despite 53% of RPC staff being Nauruan, there was a sense that the local community had limited access to information about the RPCs, and almost no contact with people in held detention. Discussions with representatives of the Nauruan Government, the Nauruan Operational Managers

[rr] Meeting with RoN hospital staff, 18 February 2014.

and Nauruan police suggested that there is almost complete separation of the RPCs from the local community. Currently there are limited excursions by people in the RPCs, the pilot school program is for 11 students only, and only one incursion (Local community coming to the RPCs) was identified. The previous RPC newsletter has not been maintained, although this was identified as a useful resource.

During the twilight mental health session, which was attended by members of the local police force and judiciary, it quickly became apparent that there appears to be widespread fear amongst the community and a lack of understanding about the transferees at the centre, which had been exacerbated by the July 19 2013 riot. It was readily apparent that the majority of attendees were not aware of what drives asylum seekers to leave their countries of origin and why they may not be accepting of settlement in Nauru when they had planned to settle in Australia. This coupled with negative media coverage about Nauru appears to have created broadly negative feelings in the community, particularly toward the single adult male population.

Regular information sessions with the local community, RPC newsletters, regular activities with the local community and regular consultation will be important factors to improve the relationship with the Nauruan community.

4.9. Cost

There was no information available on the cost of running the RPCs, including IHMS and stakeholder services. The scale of the operation is vast, and in fact so large, it is difficult to convey within this report.

4.10. Future planning - resettlement

Seven sites have been identified as potential areas for accommodation for people with a positive RSD and eligible for resettlement. Stakeholder staff reported development of infrastructure or service provisions for this population had not been substantive and at this time was not available.

During our visit, it was apparent that the processing of claims is experiencing ongoing delays, that conditions are at risk of destabilising, that there is no (unowned) land where people might settle, that there is no room in Nauruan schools for detained children, that there will be few teachers in the next two years, that there are limited or no employment prospects, and that there are critical issues with the RoN hospital, the health workforce on Nauru, and health care in all areas, and especially for children.

We also note that a 25 – 50% increase in the population of Nauru presents enormous challenges with infrastructure, including water, power, sewerage, sewage and waste disposal. It is not clear the environment on Nauru will be able to tolerate the extra waste, and there are concerns about water contamination (see sections 4.4.4), adding to existing environmental damage.

Finally, the Nauruan Operational Managers, and representatives of the Nauruan Government indicated that communication with the Nauruan community concerning potential resettlement of people in held detention was still nascent.

5. Recommendations

5.1. General

1. **Provide clear information on the timing of the Refugee Status Determination process and plans for settlement to ameliorate the mental heath impact of ongoing uncertainty and reduce the risk of destabilisation.**
    a. Information will need to be updated regularly and presented in appropriate languages.
    b. Providing a central resource for information – e.g. an internal website would allow consistency in information delivery and an accountability and assessment framework.
    c. This information should also be available to the Nauruan community.
2. **Analyse, monitor and address the environmental impact of the Regional Processing Centres on Nauru.**
3. **Clarify criteria for exclusion for transfer to places of offshore processing.**
    a. Clarify standards used to determine 'fit to fly' and 'fit for offshore processing'.
    b. Develop and implement exclusion criteria for conditions requiring medical review, therapy and monitoring that cannot be provided on Nauru, and ensure there is formal agreement between the Australian Government and Government of Nauru on exclusion criteria.
4. **Develop criteria for medical transfer and evacuation and provide regular reporting on transfers and evacuations.**
    a. Ensure criteria are developed for children, adults, and pregnant women, and that they provide guidance across the physical and mental health domains.
    b. Review of clinical notes to determine whether improved screening may have reduced the need for transfers.
    c. Independent oversight of medical transfer requests, including those that have been declined.
5. **Ensure independent external oversight of the guardianship process for unaccompanied minors.**
6. **Clarify how consent is obtained to share health information between stakeholders**, and examine whether this is informed consent.
7. **Clarify the clinical governance framework within IHMS, including how complaints or concerns are handled.**
    a. Clarify practical arrangements for AHPRA to investigate concerns about a Australian registered health providers
    b. Clarify how quality issues and adverse events will be handled by the Government of Nauru Department of Health, which has oversight for all health providers, including providers not registered in Australia.
8. **Extend the access to telephones for people to communicate with relatives** as a means to reduce distress and improve wellbeing.

5.2. Mental health service provision

1. **Ensure robust case management and welfare based models of care** with:

a. An independent audit of the new case management model within the next 3 months, with focus on management of clients with a PSP or behavioural management plan, any children where there are child protection concerns and other vulnerable groups including unaccompanied minors.
b. Independent review of mental health care models and policies, with the intent of enhancing protective factors, and recognising/modifying risk to reduce self-harm, suicide and the potential for violence.
c. Review of clinical notes within 3 months to allow oversight of consistently and quality of mental health screening and consequent actions.

2. **Clarify the child mental health screening process, and align this process with development and educational screening as these are developed and implemented.**
    a. Clarify the experience and qualifications of psychologists seeing children.
3. **Strengthen mental health staffing and models of care.**
    a. Ensure the psychiatry position within IHMS staffing is filled.
    b. A model of mental health care similar to a community based treatment model is likely to be efficient – where decision making by a psychiatrist can be implemented by other mental health clinicians within a team.
    c. Implement the mental health clubhouse model as a risk mitigation strategy – by having a designated place (room) outside RPC2 where people can have a safe change of environment, and supported 'timeout' through access to mental health staff.
4. **Develop and disseminate a code black policy.**
5. **Improve and increase external activities, and local community engagement as a matter of urgency** (see also 1.8).
    a. Extending the external school pilot program is likely to be an efficient way of improving child and adolescent mental health and will also enhance community engagement and understanding.

5.3. Physical health service provision

1. **Develop and progress a Memorandum of Understanding between IHMS and the RoN hospital** addressing service provision, access to care and equity.
2. **Progress a review and needs analysis of the RoN Hospital facilities, to inform rebuilding or redevelopment plans in the face of an expanded population.**
    a. Explore options for transition or 'step down' of care for people with a positive refugee status determination and the impact this will have on Nauruan community. Shared resources, and defining a unified standard of care for post release and local community will be required.
3. **Ensure consistency between DIBP health screening protocols and IHMS procedures.**
    a. Consider the intention of screening and additional need related to conditions in the RPC – the prevalence of health conditions in refugee/asylum seeker cohorts justifies comprehensive screening at all ages, and close living conditions amplify the risk of communicable disease transmission. There is a clinical argument to detect and treat latent tuberculosis, and *Strongyloides* in addition to current screening protocols.
    b. We suggest guidelines align with Australian onshore refugee screening guidelines, and be available for expert review and input.

c. Review of clinical notes to allow audit and oversight of screening implementation and immunisation service provision.

4. **Ensure immunisation catch-up is completed across the lifespan.**
    a. The use of the Australian schedule with the additional vaccines of hepatitis A, typhoid, and BCG is appropriate and we commend IHMS planning on this issue.
    b. Annual Influenza vaccine should be added to the vaccination schedule.
    c. Review of clinical notes to allow audit and oversight of immunisation service provision.
5. **Ensure there is a working medical incinerator.** Clarify obstacles to repair of the RoN incinerator as part of the review/analysis of the RoN hospital, although medical incineration facilities at IHMS may be required as an interim measures.
6. **Examine ways to extend laboratory and microbiology services on Nauru** – specimens are currently sent to Australia, which presumably increases cost and complexity.
7. **Examine the feasibility of setting up a blood bank on Nauru** – linked to the review and needs analysis of the RoN hospital, noting the need to ensure equipment, expertise, facilities, stable power and the need to screen for blood borne viruses and antibodies.
8. **Ensure that all welfare and security staff have basic first aid training** as part of their induction, including use of Automatic External Defibrillators.
9. **Improve IT systems efficiency:**
    a. Ongoing clinician directed evaluation of the new software system, reviewing and addressing systems issues.
    b. Ensure information from the previous Chiron system is available for clinicians within the new Apollo system.
    c. Where possible, download guidelines and resources to desktop computers, reducing dependency on inefficient internet access and allowing improved access to evidence based guidelines.
10. **Improve the appointment scheduling system** to reduce the failure to attend rate and improve efficiency.
    a. We suggest interpreters are scheduled each day to interpret the appointment requests in the presence of an IHMS administration, allowing IHMS to note the key issues and expedite review.
    b. Ensure welfare staff provide people with their appointment slips in a timely manner.
11. **Extend ambulance capacity,** improving the ability to provide resuscitation within the vehicle.

5.4. Child health service provision

1. **Improve child health screening:**
    a. Discrepancies between DIBP protocols and IHMS procedures should be addressed
    b. Child health screening should be extended to include screening for acute/chronic health issues, testing to detect nutritional deficiencies, communicable/infectious diseases (TB screening, blood borne virus screening, parasite screening), and also include mental health screening and developmental review.
    c. Screening protocols should be regularly reviewed and subject to independent oversight.
    d. Review of clinical notes to allow audit and oversight of screening implementation.

2. **Increase staff experience and expertise in paediatrics, including experience in paediatric resuscitation and child protection.**
    a. Consider employing a paediatrician.
    b. Clarify whether psychology staff have child psychology qualifications, and support employment of staff with relevant qualifications.
    c. Clarify the STC paediatric nurse role, and how this will align with maternal and child health nursing within IHMS.
    d. Clarify credentialing criteria for Maternal and Child Health Nurse staff.
    e. Advanced Paediatric Life Support training should be mandated for all nursing, paramedic and medical staff – in addition to Advanced Life Support training.
    f. Support and mandate training in child protection and forensic paediatrics for senior medical and nursing staff.
    g. Strengthen external support for child health emergencies, including through as telehealth or phone based support, and involve the Nauru paediatrician where time and resources permit. This would be analogous to support provided to remote Australia by agencies such as the Royal Flying Doctor Service or Paediatric Emergency Transport teams, and would be an appropriate measure to mitigate the risk of deterioration and death with current times to evacuation.
3. **Develop and implement a robust child protection policy, and support the Government of Nauru to progress the proposed child protection framework.**
    a. Support staff training in this area – as above.
    b. Clarify how the forensic chain of evidence will be handled given specimens will need to be sent to Australia (e.g. clinical photography, and testing to examine for the presence of DNA or semen in samples obtained during a protection assessment).
    c. Clarify police and judicial capacity to progress child protection cases within the Nauru legal system.
    d. Clarify the duty of care, and implications of child protection concerns in minors under Guardianship orders.
4. **Implement exclusion criteria for transfer of minors with conditions requiring medical review, therapy and monitoring that cannot be provided on Nauru.**
    a. Current conditions and resources in held detention are not appropriate to manage children with chronic health issues (such as organ impairment), developmental delay, disability (physical or intellectual), or severe mental health issues. Clarification of the duty of care and the expected standard of care will be important, and we acknowledge people are often from resource poor settings.
    b. There is need to recognize that the current medical resources and environment mean the risks to newborns are substantial, and that there may be neonatal deaths in the RPCs.
    c. Develop a formal agreement between the Australian Government and Government of Nauru on exclusion criteria for minors.
5. **Support access to education,** especially education based in the Nauruan community to support child development, improve wellbeing and mental health, and facilitate community engagement.
    a. Progress the pilot education program based in Nauruan schools.

b. Examine whether it might be possible to share teaching resources to facilitate RPC students attending Nauruan schools, and support Nauruan students and teachers.
c. Clarify the English as an Additional Language (EAL) qualification of STC teaching staff.
d. Ensure there are appropriate facilities available for classroom education.

6. **Support access to meaningful play:**
    a. Provide toys and sporting equipment.
    b. Support parenting through provision of play groups and parent groups.
    c. Support early childhood care as a form of respite, existing resources and skills within the RPC population might be utilised.

5.5. Maternity and obstetric services

1. **Define obstetric risk assessment and transfer criteria and make these available for expert review and independent oversight.**
2. **Establish independent oversight of obstetric care and statistics.**
3. **Identify reasons for the disparity in maternal and neonatal mortality statistics** between Nauru and Australia to direct risk minimisation strategies, including obstetric care and assessing the feasibility of a blood bank.

5.6. Dental services

1. **Establish dental services** noting the high prevalence of oral health issues and lack of current services.
    a. Ensure there are services for both children and adults.
    b. Ensure Nauruan community access to dental care is not compromised.

5.7. Public health

1. **Clarify the reports of recent dengue cases** – if confirmed this will require:
    a. Improved vector control, with possibility to use existing entomology expertise currently deployed to the Manus Island RPC.
    b. Development of IHMS protocols for management of Dengue related disease.
    c. Review of communication lines between Nauruan Centers for Disease Control, the RoN hospital, IHMS and DIBP.
    d. Consideration of the implications for Australian health systems, with a high number of fly in/fly out staff, and a single aircraft carrier flying between Nauru, Fiji and Australia.
2. **Improved child health screening (as above).**
3. **Review of the intention of screening (as above)** – with extension of tuberculosis screening to include detection and management of latent tuberculosis infection to reduce the risk and transmission of active disease.
4. **Discrete availability of condoms.**
5. **Addition of influenza vaccine to the current immunisation schedule** (as above).
6. **Review and monitoring of waste, sewage and water management.**
    a. Ensure the waste minimization system is operational as a matter of urgency.
    b. Analyse and monitor the impact of sewage/sewerage management, considering environmental and communicable disease implications.

5.8. Community engagement and equitable access

1. **Ensure there is clarity and communication around settlement planning** (as per section 5.1)
2. **Extend and increase activities leading to regular engagement with the local community.**
    a. Progress the pilot education program based in Nauruan schools (as above).
    b. Extend and increase excursions into the Nauruan community.
    c. Develop 'incursions' allowing the Nauruan community coming to the RPC, and examine ways to incorporate discussion of Nauruan culture and way of life.
3. **Address disparities between Australian and Nauruan child vaccination schedules.**
4. **Improve equity in access to medical resources across the Nauruan community and people in the RPCs** – Explore options for transition and a unified standard of care as above.
5. **Re-establish the RPC newsletter.**

Action requested	Urgency (high, moderate non-urgent)	Stakeholder Responsible
Information on future planning – settlement – where people will live, how they will access water, food, education, employment, health care, housing, and how they will support themselves.	High	GoN/DIBP
Information on future planning - management of outcomes of RSD process, risk minimisation strategies, establishing a Refugee Review Tribunal.	High	GoN/DIBP
Review of random selection of clinical notes of adults and children (see 4.8) to assess health screening, mental health screening and immunisation catch-up.	High	DIBP/IHMS
Review of obstetric transfer criteria and data.	High	DIBP/IHMS
Review of case management files for people who have had critical incidents and for people at risk of self-harm within the next three months.	High	DIBP/STC/ Transfield
Clinical information and data on medical transfer statistics, including where requests are declined (and reasons for being declined).	High	DIBP/IHMS
Review of IHMS master tracker immunisation, tuberculosis and blood borne virus spreadsheets.	High	DIBP/IHMS
Clarification of communication lines between Darwin CDC, Nauru CDC, IHMS and DIBP.	High	GoN/DIBP/ IHMS
Serological documentation on recent Dengue cases.	High	GoN
Update from GoN on plan for repairs to medical incinerator.	High	GoN
Information on total duration of detention for the current population in Nauru RPC.	Moderate	DIBP
Ongoing access to medical evacuation and transfer statistics, with inclusion of age, demographic data, and clarification of repeated/multiple episodes (i.e. linked episodes) and linked PSP information .	Moderate	DIBP
Ongoing access to PSP/self harm statistics with inclusion of age, demographic data, and clarification of repeated/multiple episodes (i.e. linked episodes).	Moderate	DIBP
Information on IHMS clinical governance framework for Nauru and protocols for adverse events or reporting quality assurance issues.	Moderate	IHMS
Information on the proportion of IHMS staff with APLS and clarity of the extent of child health experience		
Information on how informed consent is obtained prior to HIA about information sharing with stakeholders.	Moderate	IHMS

Information on how complaints about professional conduct of IHMS staff are managed.	Moderate	GoN
Regular data on medical isolation and notifiable diseases.	Moderate	IHMS

References

1. About Nauru. The Government of the Republic of Nauru, 2014. (Accessed 28 February 2014, at http://www.naurugov.nr/about-nauru/our-country.aspx)
2. Nauru: health profile. World Health Organization, 2013. (Accessed 18 August 2013, at http://www.who.int/countries/nru/en/.)
3. Nauru National Sustainable Development Strategy 2005 - 2025. Government of Nauru, 2005. (Accessed 14 February 2014, at http://www.sprep.org/att/IRC/eCOPIES/Countries/Nauru/2a.pdf.)
4. Sustainable integrated water resources and wastewater management in Pacific Island Countries. National integrated water resource management diagnostic report. Nauru. SOPAC Water, Sanitation and Hygiene. Pacific Islands Applied Geoscience Commission, 2007. (Accessed 28 February 2014, at http://www.pacificwater.org/userfiles/file/GEF IWRM Final Docs/MR0640nAURU.pdf.)
5. Schedule to the Nauru-Australia partnership for development. Partnership priority outcome 2: Improved education. Implementation strategy. Department of Foreign Affairs and Trade, Australian Government. (Accessed 11 February 2014, at http://aid.dfat.gov.au/countries/pacific/nauru/Documents/nauru-education-strategy.pdf.)
6. Nauru Partnership Priority Outcome 2: Improved Education. Australian Government, 2014. (Accessed 11 February 2014, at http://aid.dfat.gov.au/Publications/Pages/nauru-education-strategy.aspx.)
7. Department of Immigration and Border Protection. Transferee statistics for Nauru Offshore Processing Centre. Canberra: Australian Government, ; 2014.
8. Hamburger K. Nauru Review 2013 - Executive Report of the Review into the 19 July 2013 Incident at the Nauru Regional Processing Centre. In. Canberra: Department of Immigration and Border Protection, Australian Government; 2013, 10p.
9. National Water Quality Management Strategy. Australian Guidelines for Sewerage Systems. Effluent Management. Commonwealth of Australia, 1997. (Accessed 28 February 2014, at http://www.environment.gov.au/system/files/resources/e52e452b-a821-4abe-9987-23988790e353/files/sewerage-systems-effluent-man-paper11.pdf.)
10. Stakeholder and Health Strategy Section, Detention Health Services Branch, Detention Infrastructure and Services Division, Department of Immigration and Border Protection. Detention Services Manual. Chapter 6 – Detention health. Antenatal screening. In. Canberra: Department of Immigration and Border Protection, Australian Government; 23 November 2013:1-8.
11. Human Rights and Equal Opportunities Commission. A Last Resort? The report of the national inquiry into children in immigration detention. Sydney: Human Rights and Equal Opportunities Commission. ; 2004. 942 p.
12. Human Rights and Equal Opportunities Commission. Those who've come across the seas: Detention of unauthorised arrivals. Sydney: Human Rights and Equal Opportunities Commission. ; 1998. 282 p.
13. Newman L, Proctor N, Dudley M. Seeking asylum in Australia: immigration detention, human rights and mental health care. Australas Psychiatry 2013;21:315-20.
14. Dudley M, Steel Z, Mares S, Newman L. Children and young people in immigration detention. Curr Opin Psychiatry 2012;25:285-92.

15. Steel Z, Momartin S, Silove D, Coello M, Aroche J, Tay KW. Two year psychosocial and mental health outcomes for refugees subjected to restrictive or supportive immigration policies. Soc Sci Med 2011;72:1149-56.

16. Robjant K, Hassan R, Katona C. Mental health implications of detaining asylum seekers: systematic review. Br J Psychiatry 2009;194:306-12.

17. Steel Z, Silove D, Brooks R, Momartin S, Alzuhairi B, Susljik I. Impact of immigration detention and temporary protection on the mental health of refugees. Br J Psychiatry 2006;188:58-64.

18. Porter M, Haslam N. Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis. Jama 2005;294:602-12.

19. Steel Z, Momartin S, Bateman C, et al. Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia. Australian and New Zealand journal of public health 2004;28:527-36.

20. Steel Z, Silove DM. The mental health implications of detaining asylum seekers. Med J Aust 2001;175:596-9.

21. Stakeholder and Health Strategy Section, Detention Health Services Branch, Detention Infrastructure and Services Division, Department of Immigration and Border Protection. Detention Services Manual. Chapter 6 - Detention health. General health screening and management. In. Canberra: Department of Immigration and Border Protection, Australian Government; 23 November 2013:1-14.

22. Stakeholder and Health Strategy Section, Detention Health Services Branch, Detention Infrastructure and Services Division, Department of Immigration and Border Protection. PAM3: Act - Detention Services Manual. Chapter 6 - Detention health. Mental health policies. Minors in immigration detention - Health screening policy. In. Canberra: Department of Immigration and Citizenship, Australian Government; 15 May 2012:1-6.

23. Instructions for medical and radiological examination of Australian visa applicants. Department of Immigration and Citizenship, 2012. (Accessed 7 January 2014, at http://www.immi.gov.au/gateways/panel_doctors/conducting_medicals/instructions/panel-doctors-instructions.pdf.)

24. Protiviti Report. Internal Audit Report. Management of the Risk of Communicable Diseases in Irregular Maritime Arrivals. 2 May 2013. In. Canberra: Department of Immigration and Citizenship, Australian Government; 2013. 26p.

25. Departure Health Check. Refugee and Humanitarian Entry to Australia. Visas, Immigration and Refugees. Australian Government, 2013. (Accessed 6 May 2013, at http://www.immi.gov.au/visas/humanitarian/offshore/travelling.htm - c.)

26. Foundation House. Promoting Refugee Health: a handbook for doctors and other health care providers caring for people from refugee backgrounds. 3rd ed. Melbourne: Foundation House; 2012.

27. Murray RJ, Davis JS, Burgner DP, et al. The Australasian Society for Infectious Diseases guidelines for the diagnosis, management and prevention of infections in recently arrived refugees: an abridged outline. Med J Aust 2009;190:421-5.

28. McGillivray G, Skull SA, Davie G, et al. High prevalence of asymptomatic vitamin D and iron deficiency in East African immigrant children and adolescents living in a temperate climate. Arch Dis Child 2007;92:1088-93.

29. Sheikh M, Pal A, Wang S, et al. The epidemiology of health conditions of newly arrived refugee children: a review of patients attending a specialist health clinic in Sydney. J Paediatr Child Health 2009;45:509-13.

30. Johnson D. Rates of infectious diseases and nutritional deficiencies in newly arrived African refugees. Central Northern Adelaide Health Service: Government of South Australia; 2007. 44 p.

31. Johnston V, Smith L, Roydhouse H. The health of newly arrived refugees to the Top End of Australia: results of a clinical audit at the Darwin Refugee Health Service. Australian Journal of Primary Health 2011; http://dx.doi.org/10.1071/PY11065.

32. Paxton GA, Sangster KJ, Maxwell EL, McBride CR, Drewe RH. Post-arrival health screening in Karen refugees in australia. PLoS One 2012;7:e38194.

33. Tiong ACD, Patel, M.S., Gardiner, J. et al. Health issues in newly arrived African refugees attending general practice clinics in Melbourne. Medical Journal of Australia 2006;185:602-6.

34. Martin JA, Mak DB. Changing faces: A review of infectious disease screening of refugees by the Migrant Health Unit, Western Australia in 2003 and 2004. Med J Aust 2006;185:607-10.

35. Lucas M, Nicholl., McKinnon, E., Whidboren, R., Lucas, A., Thambiran, A., Burgner, D., Waring, J. and French, M. A prospective large-scale study of methods for the detection of latent *Mycobacterium tuberculosis* infection in refugee children. Thorax 2011;65:442-8.

36. Gray K, Wood N, Gunasekera H, et al. Vitamin D and Tuberculosis Status in Refugee Children. Pediatr Infect Dis J 2011.

37. Rice JE, Skull SA, Pearce C, Mulholland N, Davie G, Carapetis JR. Screening for intestinal parasites in recently arrived children from East Africa. Journal of paediatrics and child health 2003;39:456-9.

38. Tiong A, Heinrich-Morrison K, Buttery J. Lessons from malaria screening for newly arrived refugees. Australian and New Zealand journal of public health 2006;30:83-4.

39. Cherian S, Fagan JM, Thambiran A, Geddes J, Burgner D. Severe Plasmodium falciparum malaria in refugee children despite reported predeparture antimalarial treatment. The Medical journal of Australia 2006;185:611.

40. Hurie MB, Mast EE, Davis JP. Horizontal transmission of hepatitis B virus infection to United States-born children of Hmong refugees. Pediatrics 1992;89:269-73.

41. Mahoney FJ, Lawrence M, Scott C, Le Q, Lambert S, Farley TA. Continuing risk for hepatitis B virus transmission among Southeast Asian infants in Louisiana. Pediatrics 1995;96:1113-6.

42. Maloney M, Spink P, Casey S, Marlow L, Murphy B. Asylum Seeker Health Orientation and Triage Model for Northern and Western Metropolitan Melbourne Evaluation Report. Melbourne: Victorian Refugee Health Network, ; 2014. 42p.

43. Strongylos F. Asylum seekers integrated healthcare pathway. Health orientation session pilot: September - December 2012. Report summary. Melbourne: Medicare Local South Eastern Melbourne, Monash Health, Australian Red Cross. ; 2013. 14p.

44. WHO vaccine-preventable diseases: monitoring system. 2013 global summary. World Health Organization, 2013. (Accessed 18 August 2013, at http://apps.who.int/immunization_monitoring/globalsummary/schedules.)

45. Traveler's health. Vaccines, medicines, advice for clinicians by destination: Nauru. Centers for Disease Control and Prevention, 2014. (Accessed 7 January 2014, at http://wwwnc.cdc.gov/travel/destinations/clinician/children.extended_student.immune_compromised.pregnant/nauru.)

46. Stakeholder and Health Strategy Section, Detention Health Services Branch, Detention Infrastructure and Services Division, Department of Immigration and Border Protection. Detention Services Manual. Chapter 6 - Detention health Psychological support program (PSP). In. Canberra: Department of Immigration and Citizenship, Australian Government; 15 May 2012:1-28.

47. Western Pacific Region. Health Information and Intelligence Platform. Country profiles. World Health Organization, 2014. (Accessed 10 January 2014, at http://hiip.wpro.who.int/portal/Countryprofiles.aspx.)

48. Report of the United Nations High Commissioner for Refugees, Questions relating to refugees, returnees and displaced persons and humanitarian questions. Assistance to unaccompanied refugee minors. Report of the Secretary-General. United Nations General Assembly. 52nd session, 7 August 1997. (Accessed 18 August 2013, at http://www.un.org/documents/ga/docs/52/plenary/a52-273.htm.)

49. Fazel M, Stein A. The mental health of refugee children. Archives of disease in childhood 2002;87:366-70.

50. Newman LK, Steel Z. The child asylum seeker: psychological and developmental impact of immigration detention. Child Adolesc Psychiatr Clin N Am 2008;17:665-83, x.

51. Adewuya AO, Ola BA, Dada AO, Fasoto OO. Validation of the Edinburgh Postnatal Depression Scale as a screening tool for depression in late pregnancy among Nigerian women. J Psychosom Obstet Gynaecol 2006;27:267-72.

52. Bergink V, Kooistra L, Lambregtse-van den Berg MP, et al. Validation of the Edinburgh Depression Scale during pregnancy. J Psychosom Res 2011;70:385-9.

53. Traveler's Health. Health Information for Travelers to Nauru. Clinician View. Centers for Disease Control and Prevention, 2013. (Accessed 10 December 2013, at http://wwwnc.cdc.gov/travel/destinations/clinician/none/nauru.)

54. Guidelines for Dengue surveillance and mosquito control. Second ed. Manila: Regional Office for the Western Pacific, World Health Organization; 2003.