

Chapter 9

Mental Health of Children in Immigration Detention

Contents

9.	Mental Health of Children in Immigration Detention	359
9.1	What are children's rights regarding mental health and development in immigration detention?	360
9.2	What policies were in place to prevent and treat the mental health problems of children in detention?	363
9.2.1	Department policy on mental health and development	363
9.2.2	ACM policy on mental health and development	364
	(a) Assessment on arrival by ACM	364
	(b) External referrals	364
	(c) Suicide prevention	365
	(d) High Risk Assessment Team (HRAT)	365
	(e) Voluntary starvation	365
9.2.3	State authority involvement in the mental health of children	366
9.3	What factors contribute to the mental health and development problems of children in detention?	367
9.3.1	Torture and trauma prior to arrival in Australia	368
9.3.2	Length of detention	370
9.3.3	Uncertainty and negative visa outcomes	371
9.3.4	Breakdown of the family unit	373
	(a) The impact of detention on parenting generally	373
	(b) The impact of the declining mental health of parents on their children	375
	(c) The connection between detention and children taking on adult roles	380
9.3.5	Living in a closed environment	381
9.3.6	Safety	383
9.3.7	Treatment by detention staff	385
	(a) Treatment with respect	385
	(b) Calling children by number	388
	(c) Training on how to treat children	389
9.3.8	Findings regarding the factors leading to mental health and development problems for children in detention	389

9.4	What was the nature and extent of the mental health and development problems suffered by children in detention?	391
9.4.1	Developmental problems	396
9.4.2	Depression and post traumatic stress disorder (PTSD)	399
	(a) Detainee reports	399
	(b) Expert mental health reports	400
	(c) Case examples of depression and post traumatic stress disorder	402
9.4.3	Self-harm	404
	(a) Exposure of children to self-harm by others	405
	(b) Prevalence of self-harm by children	408
9.4.4	Long-term impact of the detention experience on children and the Australian community	410
9.4.5	Findings regarding the seriousness of mental health and development problems for children in detention	411
9.5	What measures were taken to prevent and treat mental health and development problems in detention?	412
9.5.1	Identification of mental health problems	412
9.5.2	Treatment of the mental health problems of children in detention	413
	(a) Numbers of mental health staff	413
	(b) Turnover of mental health staff	415
	(c) Referral to specialist mental health services	416
9.5.3	Prevention of self-harm of children in detention	418
	(a) High Risk Assessment Team (HRAT)	420
	(b) Observation rooms	420
	(c) Parental care	422
9.5.4	Can mental health problems be treated in detention?	423
9.5.5	Implementation of recommendations regarding the mental health of children	424
9.5.6	Findings regarding the treatment of mental health problems	428
9.6	Summary of findings regarding the mental health and development of children in detention	429
9.7	Case studies	432
9.7.1	Case Study 1: Declining mental health of a family in Woomera	432
9.7.2	Case Study 2: Declining mental health of a family in Woomera	438
9.7.3	Case Study 3: History of self-harm by a 14-year-old boy in Woomera	442
	Endnotes	445

9. Mental Health of Children in Immigration Detention

This chapter addresses the impact of the detention environment on the mental health of children and the measures taken to address their mental health needs. Consistent with the breadth of protection given to the welfare of children under the *Convention on the Rights of the Child (CRC)*, the Inquiry uses the term mental health to describe the psychological well-being of children as well as diagnosed psychiatric illness.

During Inquiry visits to immigration detention facilities, large numbers of children and parents reported on the impact of detention on their psychological well-being. The Inquiry also interviewed former detainee children in focus groups in order to gain an understanding of the impact of detention on their psychological well-being. Many of those children and parents are quoted in this chapter.

As a result of these conversations the Inquiry requested primary records concerning certain children and families who have been held in immigration detention centres.¹ The Inquiry sought the fullest possible record regarding the mental health concerns and treatment for certain children in long-term detention. The primary records obtained through this process included Australasian Correctional Management Pty Limited (ACM) medical records, reports by external health consultants, incident reports, High Risk Assessment Team (HRAT) records, and reports from the State child welfare authorities and mental health agencies. Documents from the South Australian child welfare agency, the Department of Human Services (DHS), and Family and Youth Services (FAYS), the section of DHS that manages these responsibilities; and the South Australian Child and Adolescent Mental Health Services (CAMHS) were particularly useful. The case studies used in this chapter are based almost exclusively on those documents.

The Inquiry also received written submissions, oral testimony and research reports from mental health experts, including several senior psychiatrists and psychologists who gave evidence that the long-term detention of children could be expected to have a negative impact on the general psychological well-being of children. The primary records obtained by the Inquiry confirmed that detention did in fact have that effect on certain children. Some of the problems suffered by children in detention include anxiety, distress, bed-wetting, suicidal ideation and self-destructive behaviour including attempted and actual self-harm.

A last resort?

Furthermore, the primary records revealed that in a smaller number of cases children had been diagnosed with specific psychiatric illnesses such as depression and post traumatic stress disorder (PTSD). The records showed that either the cause or the severity of these disorders could be linked to the children's ongoing detention. They also indicate that the quality of treatment they receive is affected by their detention.

The Inquiry does not argue that the children discussed throughout this chapter represent the experience of every child in detention. Indeed the Inquiry readily acknowledges that children who are detained for very short periods of time are less likely to have had the experiences described in this chapter. However the cases and situations described in this chapter demonstrate the connection between long-term detention and the declining psychological health of certain children and this alone is sufficient to find a breach of international law. Furthermore, it is important to keep in mind that, despite the length of this chapter, the text does not fully represent large quantities of evidence received by the Inquiry regarding the mental health of children.

This chapter addresses the following questions:

- 9.1 What are children's rights regarding mental health and development in immigration detention?
- 9.2 What policies were in place to prevent and treat the mental health problems of children in detention?
- 9.3 What factors contribute to the mental health and development problems of children in detention?
- 9.4 What was the nature and extent of mental health and development problems suffered by children in detention?
- 9.5 What measures were taken to prevent and treat mental health and development problems in detention?

At the end of the chapter there is a summary of the Inquiry's findings and three in depth case studies demonstrating the impact of detention on the mental health of these children.

9.1 What are children's rights regarding mental health and development in immigration detention?

There are many rights in the CRC which together highlight Australia's obligation to protect the mental health of children.

Article 24(1) requires the Commonwealth to ensure that all children within Australia can enjoy 'the highest attainable standard' of physical and mental health that Australia can offer. The Commonwealth must also ensure that no child in Australia is deprived of access to the health care services necessary to achieve that standard.

States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and

rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

Convention on the Rights of the Child, article 24(1)

Article 22(1) highlights the obligation to provide appropriate assistance to refugee and asylum-seeking children to ensure that their special needs are addressed. In the context of mental health it is therefore important to address the likelihood that asylum-seeking children may have suffered from trauma in their past. As the United Nations High Commissioner for Refugees (UNHCR) publication, *Refugee Children: Guidelines on Protection and Care* (UNHCR Guidelines on Refugee Children), states:

Because of the possible damaging effects of trauma that refugee children may have experienced, some children will require specialized services or treatment.²

As discussed in Chapter 4 on Australia's Human Rights Obligations, article 39 of the CRC specifically sets out Australia's obligations when children are suffering from past torture and trauma:

States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

There are two important aspects to this article. First, Australia must take 'all appropriate measures' to promote psychological recovery – this applies both to the legislature and the executive. Second the recovery must take place in 'an environment which fosters the health, self-respect and dignity of the child'. In other words, the CRC recognises the extra vulnerability of children who have suffered some past trauma to harsh environments and therefore imposes a special obligation to ensure that children can live in a healthy, happy atmosphere.

Article 6(2) also requires Australia to 'ensure to *the maximum extent possible* the survival and development of the child'. The right to development includes not just physical growth but a child's mental and emotional development.³

Chapter 8 on Safety explains that children should be protected from physical and mental violence and abuse while in detention (article 19(1)). Furthermore, they must be treated with humanity and respect and not subjected to torture or other cruel, inhuman or degrading treatment or punishment (article 37(a),(c)).

Article 37(a) of the CRC is similar to article 7 of the *International Covenant on Civil and Political Rights* (ICCPR). In 2002 the UN Human Rights Committee found that the failure to release a man from detention when 'there was a conflict between [his] continued detention and his sanity' amounted to a breach of article 7 of the ICCPR:

the continued detention of [an adult male] when [Australia] was aware of [his] mental condition and failed to take the steps necessary to ameliorate

A last resort?

the author's mental deterioration constituted a violation of his rights under article 7 of the [ICCPR].⁴

Article 3(2) requires that Australia ensures the child has 'such protection and care as is necessary for [a child's] well-being, taking into account the rights and duties of his or her parents'.

The UNHCR Guidelines on Refugee Children note the negative impact that refugee centres or camps can have on the mental health of children and their families:

The emotional development of children may be adversely affected by remaining for years in the artificial environment of a refugee centre or camp where normal life activities are impossible ... Children suffer from the negative effects of extended stays on the well-being of adult family members and the destructive effects on the family unit. Extended residence in a camp may lead to extremes of behaviour in children who may become either passive and submissive or aggressive and violent.⁵

The *United Nations Rules for the Protection of Juveniles Deprived of their Liberty* (the JDL Rules) also suggest that the mental well-being of children in the juvenile justice system may be best protected if imprisonment is used only as a last resort:

The juvenile justice system should uphold the rights and safety and promote the physical and mental well-being of juveniles. Imprisonment should be used as a last resort.⁶

In other words, the JDL Rules note the connection between the principle of detention as a measure of last resort (CRC, article 37(b)) and the protection of the mental health of children.

The JDL Rules also provide some guidance as to how to protect and promote the mental health of those children who are detained. For example any mental health problems should be noted on admission to a detention facility.⁷ Children should be provided facilities and services 'that meet all the requirements of health and human dignity'.⁸ There should be programs and activities that are designed to foster their health and self-respect.⁹ Medical officers should notify the detention authorities if a child's physical or mental health 'will be injuriously affected by continued detention, a hunger strike or any condition of detention'.¹⁰ Moreover, there should be:

provision of the type of care best suited to the particular needs of the individuals concerned and the protection of their physical, mental and moral integrity and well-being.¹¹

Article 3(1) of the CRC requires Australia's administrative and legislative bodies to take all appropriate measures to ensure the best interests of the child are a primary consideration in all actions that affect children. Given the connection between a child's mental health and his or her best interests, the Commonwealth legislature and executive should ensure that a child's mental health is a primary consideration in all decisions relating to the immigration detention of children.

9.2 What policies were in place to prevent and treat the mental health problems of children in detention?

As with the provision of other services, the Department of Immigration and Multicultural and Indigenous Affairs (the Department or DIMIA) recognises that it has 'a duty of care in relation to the health of all detainees in immigration detention'. It is important to note that with regard to mental health, ACM was contractually responsible for providing mental health services to detainees over the period of the Inquiry.¹² The Department was responsible for monitoring the provision of that service. ACM emphasised to the Inquiry their view that mental health problems amongst children and their families in detention are often caused by factors beyond their control, and that at times, 'services required to address a particular detainee need cannot be delivered due to locational, situational or other environmental circumstances'.¹³

9.2.1 Department policy on mental health and development

With respect to mental health, the Department states that:

There is a range of psychological services available on site or by referral to specialists. ...

Care needs are attended to by qualified, registered and appropriately trained health care professionals. The Services Provider seeks to employ, where possible, health professionals who have experience in the provision of health care to people who have suffered from torture and/or trauma.¹⁴

The contractual standards with which ACM had to comply regarding mental health services in immigration detention are contained in the Immigration Detention Standards (IDS).

As outlined in other chapters, the IDS require the provision of social, cultural, recreational and educational activities, important to the preservation of mental health.¹⁵ They also require that '[e]ach detainee is treated with respect and dignity'.¹⁶ The IDS underline the importance of ensuring that staff at immigration detention facilities can recognise and respond to mental illness:

Staff are trained to recognise and deal with the symptoms of depression and psychiatric disorders and to minimise the potential for detainees to do self harm.¹⁷

Furthermore, the IDS require that all staff have an 'appreciation of the anxiety and stress detainees may experience'¹⁸ and that '[m]edical personnel have the capacity to recognize, assess and deal with detainees who have suffered torture or trauma'.¹⁹

The IDS require the assessment of detainees upon their arrival for mental health as well as for physical health needs:

The care needs of each new detainee are identified by qualified medical personnel as soon as possible after being taken into detention. The medical officer has regard not only to the detainee's physical and mental health but also the safety and welfare of other detainees, visitors and staff.²⁰

A last resort?

There are further requirements for the care of detainees who have been identified with a mental illness:

- Detainees in need of psychiatric treatment have access to such services.
- Arrangements are made to move detainees who are found to be severely mentally ill or insane to appropriate establishments for the mentally ill as soon as possible.²¹

This chapter will examine whether actions were taken by the Department to ensure the protection of the mental health of children and an adequate level of mental health services.

9.2.2 ACM policy on mental health and development

The ACM Health Services Operating Manual contains the principal policies regarding mental health services in detention. The Manual notes that ACM is responsible for:

- The management and provision of clinical services for detainees with acute psychiatric disabilities, or who are at psychiatric risk.
- Ensuring seriously mentally ill detainees are assessed by a psychiatric professional; and, when appropriate, referred to local psychiatric hospitals for consideration of admission to a secure hospital as a patient under the Mental Health Act.²²

(a) Assessment on arrival by ACM

ACM policy requires that there is a health review of all detainees within 24 hours of their reception and that this review include a mental health evaluation.²³ The ACM policy regarding the management of detainees at risk of suicide or self-harm, also states that '[a]ll detainees are to be screened and assessed for risk of self-harm or suicide upon arrival at a Detention Centre'.²⁴

(b) External referrals

The ACM policy regarding referral of a detainee to a psychiatric centre states that '[w]here a detainee exhibits behaviour or makes verbalisations suggestive of mental illness, staff or the detainee should seek the assistance of the health care staff'.²⁵ The policy goes on to state that based on the outcome of the assessment, ACM health staff should do one of the following:

- Refer the detainee for further diagnosis, evaluation and/or treatment.
- Place the detainee on the active outpatient case-load of the psychiatric facility or the psychiatric staff on-site.
- Determine that no mental disorder is present and inform the referring staff that no psychiatric treatment is indicated.²⁶

(c) Suicide prevention

ACM also has a policy on suicide prevention, the purpose of which is to 'prevent suicidal gestures and attempts through surveillance and monitoring by health care and all other personnel'.²⁷ The policy notes the periods of time when detainees may be at risk, including after a negative decision regarding their application for a protection visa.²⁸ This policy requires that all staff members be trained to recognise potential suicide risk in detainees, that assessments should be conducted by a qualified health care professional, that procedures for monitoring a suicidal detainee should be specified, and that procedures for referral to mental health care providers should be specified.

(d) High Risk Assessment Team (HRAT)

One of the principal means through which detainees with serious mental health problems are managed within the detention environment is through the application of an At Risk Treatment Plan. This is generally referred to by ACM as the High Risk Assessment Team (HRAT).²⁹ The policy requires that detainees determined to be at risk should be closely observed until a Mental Health Status Screening can be conducted. They should then be quickly referred to the appropriate staff member within the centre.³⁰

The At Risk Plans (ARP) are developed by Health Centre staff. They are signed by both the ACM Operations Manager and the ACM Detention Manager. Once a detainee is on an ARP, they are monitored by the HRAT. The HRAT should meet each weekday to review the ARP. Specifically, the review considers:

- level of risk
- placement of the detainee in particular accommodation
- level and conditions of observation to be provided
- need for follow up health care
- need to contact family and/or friends for special visitation.³¹

The level of risk determines how often a detainee will be observed. Detention officers are responsible for maintaining At Risk Watch Logs, with all logs sighted and signed by the Detention Supervisor. Modification of a detainee's ARP or authorisation for a detainee's removal from a plan is the responsibility of the HRAT.

The policy does not contain specific comments about the management of children deemed to be at risk.

(e) Voluntary starvation

The ACM policy on voluntary starvation (hunger strikes) outlines the procedures that should be followed when a detainee commences a hunger strike, including assessment within the Health Centre, reporting to the Operations Manager and the generation of incident reports.³² Detainees on hunger strike are to be seen at least once every 24 hours by nursing staff, and at least once every three days by the medical officer in the centre.

A last resort?

The policy contains a specific section on the management of children on hunger strike. It states:

There are occasions when either parents place their children on a hunger strike or children declare they are on voluntary starvation. The management of children in this situation is somewhat different to adults, as dependent on their age they will physically deteriorate more quickly than adults.³³

The policy requires staff to notify State child welfare agencies. Parents must be informed that if the child welfare agency 'considers the child to be at risk they may be removed from the care of the parents'. The child must be seen by both nursing staff and the medical officer once every 24 hours.³⁴

9.2.3 State authority involvement in the mental health of children

As noted above, ACM has a policy of referring detainees with serious mental illnesses to external psychiatric services. These services are usually run by State governments. Furthermore, notification of concerns regarding the mental health and welfare of children are also made to State child welfare authorities.

The Department states that it relies on State authorities for advice on these issues:

State child welfare authorities have expertise in child welfare matters, and are able to advise the Department of different ways in which a child can be managed within a detention facility. This can include assistance to the parents or recommendations in relation to particular developmental needs.³⁵

As outlined in Chapter 8 on Safety, State laws operate in immigration detention facilities where they are not inconsistent with Commonwealth laws on detention. This means that while detainees may fall within a State's mental health laws, the State does not have the power to release the detainee from immigration detention. However, the Department states that:

In practice, where a detainee is found to be mentally incapable and in need of care in a psychiatric institution under State legislation, the Minister approves the psychiatric institution as a place of detention ... [which enables] ... the detainee to receive appropriate psychiatric care whilst remaining in detention at the psychiatric institution.³⁶

The situation is slightly different where a child is not sufficiently ill to be 'declared' under mental health legislation, but where State welfare agencies recommend release for their general welfare. In these cases the Department states that:

In practice the advice of the State agencies is considered and, where possible, implemented by the Department. Where a recommendation is made which cannot be fully implemented (such as a recommendation for release from detention of a child and its parents, where the parents are not eligible for the grant of a visa) the Department consults with agencies to reach a legally possible and mutually acceptable outcome for the child.³⁷

Therefore, while the Department states that it relies on State child welfare agencies for advice on the management of children, there is no legal obligation to actually follow that advice.

The State authorities' reliance on the Department to implement their recommendations marks a substantial difference to their ordinary powers to remove a child from an abusive or neglectful environment. DHS reported to the Inquiry:

So we can't utilise our legislation like we can with the rest of the community to go to the Youth Court of South Australia and get the Court to grant removal of a child.³⁸

See further section 9.5.5 of this chapter for a discussion of the effectiveness of the involvement of State psychiatric services in the treatment of children in detention with mental illness.

9.3 What factors contribute to the mental health and development problems of children in detention?

Children in detention live within an institutional context. It is important to consider both the general impact of institutional living, as well as specific factors that may affect children in immigration detention, when considering the impact of detention on the mental health of children.

The effects of institutionalisation generally on the mental health of children are well understood and documented. For example, *Bringing them home*, the report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families, referred extensively to studies showing the effects of institutionalisation.³⁹ Many other studies have also shown that institutionalised children are at a dramatically increased risk of serious mental and emotional disturbances.⁴⁰ For example, the report of the Inquiry into unaccompanied child migration to Australia during the twentieth century, *Lost Innocents: Righting the Record: Report on Child Migration* notes the adverse impact of institutionalisation on many of these children.⁴¹ Furthermore, the Forde Commission of Inquiry into the Abuse of Children in Queensland Institutions found that incidents of 'unsafe, improper or unlawful treatment of children' had occurred within institutional care settings in that State.⁴²

ACM acknowledges the general impact of institutionalisation, informing the Inquiry that its 'assertion that detention has an impact on detainees ... simply reflects the findings of at least three decades of research'.⁴³

The Alliance of Health Professionals, which includes a majority of the medical colleges in Australia, suggested that:

Current practices of detention of infants and children are likely to have both immediate and longer-term effects on children's development, psychological and emotional health.⁴⁴

A last resort?

More specifically, evidence provided to the Inquiry by children and their families, detention centre medical staff, consultant psychiatrists as well as psychiatric studies on children in detention indicate that a range of factors contribute to the presence of psychological problems in children in immigration detention. Those factors include one or more of:

- torture and trauma prior to arrival in Australia
- the length of detention
- uncertainty as to the visa process and negative visa decisions
- the breakdown of many families within detention
- living in a closed environment
- children's perception that they are not safe within detention
- treatment of children by detention staff.

Each of these factors is discussed in turn in the following sections.

Other contributing factors are noted in a 2003 study (the 2003 Steel Report) of the mental health of detainee children. This report noted that all of the children interviewed (19 children from a remote detention centre) said that boredom, isolation, poor quality food, seeing people self-harm and seeing people attempt suicide were serious problems.⁴⁵ Inadequate recreation and educational opportunities also have an impact on the mental health of children, as discussed in Chapter 12 on Education and Chapter 13 on Recreation.

9.3.1 Torture and trauma prior to arrival in Australia

Since more than 90 per cent of children in immigration detention over the period of the Inquiry have been found to be refugees, it follows that many children in immigration detention are likely to have been affected by prior experiences of trauma.⁴⁶

The Inquiry commissioned a literature review to consider factors affecting the psychological well-being of child and adolescent refugees and asylum seekers.⁴⁷ The paper concludes that:

research clearly demonstrates that refugee children and adolescents are vulnerable to the effects of pre-migration, most notably exposure to trauma. It is also apparent that particular groups in this population constitute higher psychological risk than others, namely those with extended trauma experience, unaccompanied or separated children and adolescents and those still in the process of seeking asylum.⁴⁸

The Inquiry received evidence from a range of sources that children in immigration detention may have experienced significant trauma prior to their arrival in Australia. For example, the Australian Association for Infant Mental Health (AAIMH) reported that:

Refugee parents may have experienced torture, imprisonment, persecution and institutional violence by the political regimes of their country of origin, or

have witnessed a spouse or close family members undergoing such experiences.

Many families prior to detention in Australia have experienced long and perilous journeys and been in transit for months or years in refugee camps or in countries where they have had no citizenship rights, lived in very poor and overcrowded housing and where basic needs have been barely met. Children are conceived and born in such situations of deprivation, uncertainty and with minimal or no health care.⁴⁹

The Inquiry also heard evidence that detainees were more likely than other asylum seekers to have had prior experiences of trauma:

Those who had suffered the most severe persecution are perversely at most risk of detention in Australia. This is not really surprising because these are the people most desperate to leave and hence the most likely to enter 'illegally'.⁵⁰

The Department acknowledges that pre-arrival experiences have a significant impact on the mental health of child detainees:

Of course, some of these people have had a very difficult and perilous voyage to get to Australia and they may well have other predispositions or issues in their life well before any thought of coming to Australia which might also be impacting on their personal circumstances whilst here.⁵¹

However, the Inquiry also received evidence that pre-arrival experience does not exclusively account for the mental health problems of children in detention. In other words, detention itself also had a significant impact on the mental health of children, particularly for those held in detention for prolonged periods.

International experience with refugee children resettled to Western countries indicates that while some mental health conditions from prior trauma may persist, particularly post traumatic stress reactions, children generally display a pattern of recovery and adaptation on arrival and integration in their new home.⁵²

This can be compared with a 2003 report regarding asylum seekers and their children in a remote Australian detention centre, which found that the impact of detention outweighed that of pre-migration experiences on the development of psychiatric illness:

Lifetime assessment of psychiatric morbidity indicated that there was little psychopathology amongst the children prior to arrival in Australia. One child who had witnessed severe domestic violence in Iran had multiple previous disorders. In contrast at the time of assessment, after having spent in excess of two years in detention, all children were diagnosed with at least one psychiatric disorder and most (16, 80%) were diagnosed with multiple disorders, representing a 10-fold increase in the total number of diagnoses identified.⁵³

The Migrant and Workers Resource Centre (MWRC) from Queensland conducted a study of 40 former child detainees and found that '[t]he detention of asylum

A last resort?

seekers upon their arrival in Australia has a deleterious psychological effect upon asylum seekers through maintaining or aggravating these pre-existing conditions'.⁵⁴

Furthermore, a psychiatrist who has examined several children detained at Woomera stated that detention was the worst thing that had happened to a number of them:

People are resilient and given appropriate circumstances, people can recover from the most horrible traumas, but on average you would expect a significant proportion of these children to continue to suffer, throughout their life, the effects of the detention experience. Now, that is obviously not the only traumatic experience that many of these children have had, but it is certainly – a number of the families that I've been involved with discussions about, the trauma – the traumatic nature of the detention experience has out-stripped any previous trauma that the children have had. So it has got to the point where being in detention is the worst thing that has ever happened to these children.⁵⁵

9.3.2 Length of detention

As explored in Chapter 6 on Australia's Detention Policy and Chapter 7 on Refugee Status Determination, the length of detention is determined by the legislative requirement that all children in Australia without a visa must be detained until they are granted a visa or removed from Australia. This process has, on some occasions, taken several years. Most of the children in detention in late 2003 had been detained for at least two years.⁵⁶

The Department acknowledges that 'mental health issues [are] to do with being long-term in a detention environment'.⁵⁷ The impact of the length of detention is also noted in the Woomera Department Manager's report in May 2002, which states that there is a '[c]ontinued focus on a number of families whose reactions to long-term detention demand increasingly frequent health service and psychologist attention'.⁵⁸

Although ACM emphasises that it has no control over the length of detention, it informed the Inquiry that 'the longer the period in detention the more likely the detainee is to need access to mental health services and support'.⁵⁹ ACM reported that it has:

[o]bserved a relationship between the behaviour of detainees, length of detention, critical immigration decision points and proximity to the exhaustion of visa consideration options (appeals etc).

A child formerly detained at Port Hedland told the Inquiry about the connection between declining mental health and ongoing detention:

There are children who have been there for a very long time – two to three years and they have actually done things that are very distressing, like they went up the trees and they wanted to throw themselves, trying to commit suicide. There were kids that actually stitched their mouths. Things that are so traumatic that we are now having nightmares on a daily basis with these things.⁶⁰

Mental health experts provided the Inquiry with substantial evidence that children's mental health deteriorates the longer that they are detained. For example, the Victorian Foundation for the Survivors of Torture reported that:

Children who were in detention for longer periods had significantly higher scores on the stress assessment schedule as 'the effect of length of stay appears to result predominantly from increased exposure to traumatic events within the detention centres ... further exacerbated by feelings of isolation, detachment and loss of confidence that are apparent in children who have experienced high levels of trauma'.⁶¹

DHS in South Australia, and the MWRC in Queensland, provided similar evidence to the Inquiry.⁶²

Several former ACM health staff at Woomera also observed the impact of the length of detention on mental health. For example, a doctor who worked at Woomera on two short term contracts told the Inquiry:

I can only say that the longer that they spent, the worse the effects that I saw. And that was in some way dependant on the age and the support, whether they were an unaccompanied minor or whether they simply still had the support of their parents, or even a parent. But in my experience at Woomera I would have to say that anyone who had been there longer than three months would be at grave risk, I believe, and did develop symptoms.⁶³

A psychologist who worked at Woomera from September 2000 to January 2002 set out the various phases of detention:

Family roles break down significantly. We actually started time-lining the break down of individuals. We classify the first three months as being a state of euphoria, hope, dreams. The next three months, as they are going through all of their interviews and there is anxiety starting to build up. After six months we start to see a deterioration in the emotional and psychological well-being of individuals, a significant start in the increase of self-harm. Be it hunger strikes, emotional anxiety, psychological disturbances developing, increased requests for assistance for sleep, which is an indication of depression, medication for depression, more active involvement in disturbances and in self-harm. So, yes, I have seen people age on a daily basis. I have seen middle aged men become old men in months.⁶⁴

9.3.3 Uncertainty and negative visa outcomes

The Department has suggested that mental health problems in long-term detainees is not related to the length of detention but to the fact that a visa has been refused:

the length of detention is almost always associated with refusal of visa applications ... this itself is likely to have an effect on the detainees' mental health.⁶⁵

The connection between visa refusal, the length of detention and mental health issues demonstrates one of the more serious problems caused by the current detention system.⁶⁶

A last resort?

When in detention, a visa refusal has two consequences for children. First, it leads to uncertainty about their future in Australia. Second, it leads to certainty that the child will remain in detention. This combination of factors understandably places a great deal of stress on children and their parents. The combination also magnifies the impact that either one of these outcomes might have.

The interdependence of visa processing, the length of detention and mental health is noted by a doctor who worked at Woomera from October 2000 to June 2001:

I saw when they came in with the reputation of Australia having such a good human rights track record, they were quite sure that they would be processed quickly, that their application visa would be settled within six to 12 months at the most. When after three months I could see depression set in, and after six months I could see severe depression, anxiety, self-harm and even some detainees having psychotic episodes and in lay terms, it is going mad.⁶⁷

A 2001 psychological report about detainees from Villawood also notes that the mental decline of detainees matches the stages of the visa process combined with the length of detention.⁶⁸ Each of the four successive stages is 'associated with increasing levels of distress and psychological disability':

Non-symptomatic stage: During the early months of detention, before the primary refugee determination decision, the detainee is shocked and dismayed at being detained, but these feelings are mitigated by an unwavering hope that confinement will be short-lived and that their claim will be upheld. ...

Primary depressive stage: This follows the receipt of a negative decision by DIMA and the realisation by detainees that they face a serious threat of forcible repatriation or detention for an indeterminate period, or both. The clinical presentation is consistent with a major depressive disorder, with the severity closely related to pre-existing risk factors, such as premigration exposure to trauma or personal predisposition to depression. ...

Secondary depressive stage: This typically follows the rejection of the asylum seeker's application by the Refugee Review Tribunal, the ultimate administrative level. The timing of this final rejection may vary, but generally occurs between six and eighteen months after first being detained. This stage is associated with a more severe level of psychomotor retardation and/or agitation. There is a marked narrowing of focus to issues of self-preservation and survival and an overwhelming feeling of impending doom. ...

Tertiary depressive stage: At this stage the detainee's mental state is dominated by hopelessness, passive acceptance and an overwhelming fear of being targeted or punished by the managing authorities. Affected detainees become self-obsessed and trapped in their predicament. ... The detainee's life can become dominated by paranoid tendencies, leaving them in a chronic state of fear and apprehension and a feeling that no one, including other detainees, can be trusted. ...⁶⁹

The Inquiry heard that detainees become extremely preoccupied with their application for a visa. For example, a medical practitioner who worked at Woomera reported the impact of this process on the mental health of parents and their children:

The ongoing understandable obsession with the process of requiring a visa and the lack of transparency that was associated with that, that affects a parent's mental health profoundly and has enormous effects on the children's well-being.⁷⁰

The link between visa uncertainty and mental health was dramatically displayed in January 2002. As set out in Chapter 8 on Safety, the Department's suspension of protection visa processing for asylum seekers from Afghanistan caused hunger strikes and lip-sewing.

The link between these issues is reinforced in an April 2002 DHS report on Woomera:

A general deterioration in detainee ability to cope with the uncertainty of life in the Centre has been noted over the past 4 months. This period has seen an escalation in protests, self-harm, and attempted and actual escapes. Identified factors contributing to the detainee condition:

- indeterminate length of incarceration
- cycles of raised hope Monday and Wednesday, followed by disappointment when they are not released on Tuesday and Thursday
- lack of understanding about the mechanisms/decision making process for visas
- rise in mythology about what might speed visas processing eg self harm ...

Continuous exposure to violence and self-harming behaviours is creating an unstable and unsafe environment in which psychological symptomatology such as suicidal ideation, disassociation, depression, restricted ranges of effect and anxiety are appearing in many of the children.

The mental health and personality of many of the children and young people is being severely impacted because parental guidance and authority is being undermined especially by the institutional nature of the facility.⁷¹

9.3.4 Breakdown of the family unit

The Inquiry heard extensive evidence of the breakdown of the family unit within the detention environment, in particular, from Woomera. All of the following comments concern families who have experienced lengthy periods of detention. Two of those families are discussed in detail in Case Studies 1 and 2 at the end of this chapter. Families who were detained for much shorter periods of time are less likely to experience family breakdown to such an extent.⁷²

(a) The impact of detention on parenting generally

Experts generally agree that strong parenting is crucial to the development of children.⁷³ The AAIMH told the Inquiry that detention affects the attachment relationships between parents and their children:

attachment relationships are very much undermined by both the problems of parenting in detention but also doubly undermined by the high rates of mental health problems that parents experience as well.⁷⁴

A last resort?

They also informed the Inquiry that:

... detention has a pathogenic effect on parenting. The institutional experience of parents ... very much undermines their ability to care for their children. They cannot provide for children's emotional needs while they are in a situation of deprivation themselves.⁷⁵

The head of the Department of Psychological Medicine at Adelaide Women's and Children's Hospital agrees that the detention environment has a direct and negative impact on parenting:

One of the systematic effects of detention in such a hostile environment is that ordinary people break down in their functioning, people who are competent to function as parents in a reasonably sympathetic or even an ordinarily hostile environment, in that very hostile environment lose the capacity to exercise their normal parental responsibilities. So effectively they are failing as parents.⁷⁶

In April 2002, DHS highlighted that detention takes away the normal family environment where parents provide food, festivities, income and discipline:

Detention as a process impacts on the ability of people to live normal autonomous and self-directed lives. For families in detention there are ongoing tensions that arise in parenting when everything from discipline, cooking, and family gatherings are controlled by a range of prescribed processes and procedures ordered by artificial timelines. Within this environment parents are significantly deprived of their authority and their independence as family units. Their roles as breadwinner or primary carer is undermined by forced dependence on a system over which they have no control.⁷⁷

DHS gave an example of a toddler's family who had been detained for more than seven months at the time:

Restricted parenting: Length of detention 224 days. The parents expressed concern over their lack of ability to enable the fulfillment of their parenting role, giving examples of their inability to prepare food and there not being adequate spaces for the child to play ... They reported they are often too tired or depressed to play or read to the child.⁷⁸

ACM acknowledges the impact of the detention environment on traditional parenting, stating that:

some detainee parents may have experienced negative effects of institutionalisation, whereby the inherent structures lead to a sense of loss of control over one's environment and increased dependence on that structure.⁷⁹

The Inquiry also heard that parents felt guilty and powerless; they had come to Australia to seek shelter for their children and instead put them in the hands of

detention authorities. For example, a psychologist who worked at Woomera told the Inquiry:

I saw parents age daily in detention as a result of the stress of detention. Over time many lost their ability to function effectively as parents and I saw family relationships break down. Parents felt guilt for what they thought they had done to their family in bringing them into this environment.⁸⁰

In some of the families detained at Woomera the father's traditional role disappeared completely:

Mr Z was initially coherent and appropriate but became more and more angry and distressed as the interview progressed. At first firm with his son, he was at one point rough as he dragged him away from the door. His anger and despair about their situation and his guilt about bringing his family into the current situation were palpable. He feels unable to protect them, impotent and trapped, reduced to less than human himself and unable to fulfil his role as father and husband.⁸¹

(b) The impact of the declining mental health of parents on their children

The Inquiry also received evidence that the declining mental health of parents in detention had a significant impact on children in detention. When the mental health problems of parents were so serious that they needed to be hospitalised, children ended up being separated from their parents for a period of time. This separation exacerbated the distress already felt by children.

The effect of depression on the capacity of parents to care for their children has been noted in many case files provided by the Department. Some parents, primarily mothers, have been hospitalised for major depression. Some have made numerous attempts at suicide. Others have become unable to interact properly with children or partners.

A child and family psychiatrist who assessed children detained at Woomera told the Inquiry of the long-term impact that the poor mental health of parents can have on their children:

I think there is a lot of literature which is very clear now on the impact on children of having parents with mental illness and these children are multiply disadvantaged because their parents are almost universally hopeless and despairing, sometimes so guilty about bringing their children to this environment that they feel like they should die and that their children would be better off without them.

She gave an example of a family where:

... the despair in the parents made it quite impossible for them to believe in themselves any longer as having anything to offer their children and so guilty that I think in some ways they did believe other people could offer them something better.⁸²

A last resort?

Parental depression often meant that they lost the interest and ability to keep a constant watch on their children. This exposed children to the risk of assault. In August 2002, DHS noted that:

Some staff have been critical of those parents who do not attempt to control their children's behaviour. However, other officers have said that many of these parents used to be more effective but are now (due to depression and lethargy) unable rather than unwilling to supervise their children in the compound.⁸³

The longer that families are in detention, the further the capacity of parents to care for their children is compromised.⁸⁴

Example one

In September 2002, the Flinders Medical Centre documented the deterioration of a Woomera mother's ability to care for her child:

It also appeared to the interviewer that in terms of responding to and managing her children [the mother] was overwhelmed to the point where her personal and parenting resilience already eroded by the demands of long-term detention had little to draw on. [She] reported 'When I came here I was good' and, on at least two occasions [she] used the image of pressure building in her until it burst. In other words, she described the parenting opportunities afforded to her in detention as beyond her reach. ...

Given her circumstances it was not surprising that [the mother] struggled to remain emotionally available to her children in a manner that was responsive to their individual needs. This was evident in her depressed presentation, in what she said about her children and by observations regarding the manner in which she related with them. [She] appeared helpless to assist them in their distress and seemed to have learned that whatever she attempted in their regard was likely to worsen rather than assist their situation.⁸⁵

Example two

A second example concerns a family who arrived in Australia in April 2001. The parents, son (then aged 12) and daughter (then aged 10) were accompanied by an adult daughter with her husband and their ten-week-old baby girl.⁸⁶ A year later, on 11 April 2002, the mother was admitted to the Woomera detention centre medical clinic with anxiety and severe depression. The next day she was admitted to Woomera Hospital and remained there for five months.

A May 2002 psychiatric report regarding this family notes that both children are suffering from psychiatric illness, that the 13-year-old son 'meets criteria for major depressive disorder' and that the 11-year-old daughter 'meets criteria for major depression with significant anxiety symptoms'. The father reported his 'distress and guilt' at not being able to be a better parent:

The father was quite explicit in his acknowledgement that he is unable to be a father to his children at this time. He says that he is 'too old and tired', and too angry and frightened by what he describes as 'this killing place'. He could give no suggestions as to how he might make things better for his

children or be more supportive. That is, whilst he has an empathetic appreciation of how distressed his children are, he is unable to respond to their needs because of his own despair. He is aware that he is unable to offer his children adequate care and that he is not offering adequate parenting to his children at present and this adds to his distress and guilt.⁸⁷

The report notes that the poor mental health of both parents and that the hospitalisation of the mother placed the children in the same position as unaccompanied children:

[I]n the present circumstances, and within the detention environment, neither parent is able to offer appropriate parenting to these children. ... Effectively [the children] are in the same position as unaccompanied minors. Indeed, in some respects they are worse off through having constant reminders of their parents inability to care for and protect them. They have effectively already lost their mother, due to the severity of her depression and her need for hospitalisation. Immigration authorities have recognised that it is inappropriate for unaccompanied minors to be in Woomera detention centre. On that basis alone, these children should be removed to a less traumatising environment, and, in order not to compound the trauma that they have already suffered, at least one primary caregiver should go with them.⁸⁸

A chronology of the attempts at self-harm of the boy in this family is included in Case Study 3 at the end of this chapter. Following incidents of self-harm soon after his mother was hospitalised, the son was placed in the detention centre observation units and then was admitted to Woomera Hospital. The father accompanied his son to hospital, while the (then) 11-year-old daughter was left alone in their donga (sleeping quarters), on and off for ten days.

In May 2002, the head of the Department of Psychological Medicine at Adelaide's Women's and Children's Hospital concluded that both the children in this family had:

undergone a significant deterioration in functioning during their year at Woomera, most markedly since the intensification of their mother's dysfunction led to her hospitalisation in Woomera and separation from the rest of the family.⁸⁹

Example three

In a third example, detention contributed to the postnatal depression of a mother detained at Villawood and this, in turn, had a serious impact on the child who was born in detention. The mother was assessed by a psychiatrist in March 2002 who reported that:

[She] appears to be suffering from a severe agitated depression with associated panic attacks and phobic avoidance of [her daughter]. She has become profoundly anorexic and has ceased virtually all oral intake resulting in dehydration and hypotension. She also has signs of sepsis. The combination of major depression, physical compromise and infection is potentially life threatening and requires urgent treatment in a medical facility. She needs ongoing psychiatric care and management of her post-partum condition and relationship with [her child].⁹⁰

A last resort?

A doctor who assessed the mother in April 2002 recommended that:

Regardless of whether this family is to leave Australia or not, mother and infant should be discharged from hospital only when suitable care in the community has been arranged. They should not return to the detention centre.⁹¹

In May 2002, the NSW Guardianship Tribunal noted the connection between detention and her depressive symptoms:

[The mother] was experiencing some depressive symptoms prior to her delivery. Her daughter was born in detention and her symptoms were greatly exacerbated after delivery and with exposure to various stressors. ... [She] was reviewed by a number of doctors at Villawood prior to her admission to [hospital] ... [she] was emaciated and self-harming while in detention...

[The mother] has depressive and anxiety symptoms based on fear of detention and fear of return to Iran. This is a persisting condition and the symptoms place [her] at risk as well as placing her child at risk.⁹²

A psychiatrist further noted that returning her from hospital to Villawood detention centre would exacerbate her symptoms:

If [the mother] was to return to Villawood she would be at grave risk of self harm. The response to provide intensive support to [the mother] in the detention centre environment would be to institute a suicide watch and surround her with more guards which would only serve to exacerbate her symptoms and distress. ...⁹³

The psychiatrist said that he believed that the mother would attempt suicide on return to Villawood. He quoted a suicide note from 14 May 2002 in which she states: 'I am not able to live any more in that place, 'Detention Centre''.⁹⁴

At the same time the mother reported the following:

[The mother] advised that it was very difficult for her to live in the detention centre and that she could not imagine being sent back there. She advised that for the whole year she was there, she had no appetite to eat and she cried all the time. She advised she cried at night when her husband and her baby were asleep and eventually, she would fall asleep exhausted only to have nightmares. She advised she was very worried about her baby whilst she was in the detention centre and she experienced problems overfeeding and underfeeding her baby. She was humiliated in having to ask visitors to bring clothes for her child.⁹⁵

The mother's poor mental health and her temporary separation from her child when hospitalised both had a significant impact on the child. The Director of the Office of the NSW Public Guardian reported to the Inquiry:

there were questions as to whether there were very, very early signs of some concerns about the relationship between the mother and the child, basically, because the child had been separated and the child hadn't fully bonded to the mother.⁹⁶

On 30 May 2002, the NSW Guardianship Tribunal concluded the following about the connection between detention, the mother's health and the impact it had on her parenting:

[The mother] is currently suffering from a mental illness in the form of a significant and chronic depression which is extremely exacerbated by the circumstances of her detention and the prospect of her having to return to reside in a detention centre. ... [She] has a mental illness creating a fragile mental condition whereby she is unable to adequately work through and separate the complex problems of detention, the care of her child and her plans for the future without serious effects on her mental health.

The evidence before the Tribunal on this occasion was that a return to a detention centre would almost certainly precipitate another episode of self-harm. Further, any reasonable steps that could be implemented to avoid another attempt at self-harm are only likely to exacerbate [the mother's] condition.⁹⁷

Example four

In a fourth case, a family, composed of a father, mother and five young children and a baby, were detained at Woomera for 12 months. When their refugee application was rejected staff were concerned that the parents' distress might lead to some harm to the children.⁹⁸ Both parents were isolated (the father in Oscar Compound, the mother initially in the medical centre's observation room and then Oscar Compound) and their nine-year-old daughter was left to look after her five little brothers, under the observation of ACM officers with child care experience.⁹⁹

Following the separation, ACM records indicate that supervised and limited contact between the mother and children was facilitated for the most part on a daily basis.¹⁰⁰ However, the separation itself and the manner in which the separation was managed appear to have caused distress to the nine-year-old girl.

According to the South Australian child welfare authority, who were visiting Woomera at the time, when the mother and father were taken by security staff to the medical centre there was no interpreter present to explain to the younger children what was going on.¹⁰¹ ACM staff reported the end of the child's visit as follows:

[The girl] was informed of mother's detention in observation rooms of medical, when she returned from a day trip by officers. When she was brought to medical to see her mother she was crying profusely. Officers took the child to observations after she expressed fears of being locked in. Once in with her mother they were both crying and sobbing. As the distress levels rose it was decided to remove [the girl] from the observation room. This required four female officers and [the girl] was screaming and resisting.¹⁰²

The Department asked FAYS if they would support contact between the children and their mother if it was properly supervised, and FAYS readily agreed:

DIMIA decided that just [the nine-year-old daughter] and mother could meet that afternoon and 'if they didn't get upset and refuse to part from each

A last resort?

other' then further access would occur. FAYS advised [the DIMIA Deputy Manager] that the child would be upset during contact with the mother regardless (this was normal) and that the child would not part from mother if she didn't know when she would next see her...

Despite this advice – and [the DIMIA Deputy Manager's] verbal agreement at the time – subsequent information from the Psychologist indicated that conditions about 'behaviour' were placed upon this child before her first contact.¹⁰³

ACM records also show that on another occasion the daughter was prevented from visiting her mother because of the child's 'bad behaviour'.¹⁰⁴

The Department notes that the family were only separated for a short time and that it took a number of key steps to ensure the unity of the family. These included encouraging the daughter to attend school and encouraging positive behaviour by the mother. However, as FAYS concluded, 'the decisions and actions by staff in relation to this family caused significant trauma to these children'.¹⁰⁵

The four examples set out above demonstrate that the impact of ongoing detention on parents also has an impact on the mental health of children. Sometimes the mental health problems of parents declined to the point that they were hospitalised, placed in observation rooms or separation compounds. In these cases the children were separated from one or more of their parents. While the Department and ACM sought to maintain some level of contact during these periods the separation appears to have created additional stress for children. The detention environment clearly contributed towards family breakdown and this had an impact on children.

(c) The connection between detention and children taking on adult roles

As demonstrated above, after extended periods in detention, some parents are unable to continue actively looking after their children. This sometimes leads to children taking on the adult role.

Dr Louise Newman of the NSW Institute of Psychiatry describes this as inappropriate for children:

I think sadly we are seeing, particularly in the young children, almost a situation where the children try, developmentally inappropriately, to parent the parents. The children are sometimes dealing with immigration officials and guards in a direct way, making requests because sometimes the children have better English.

They take on emotionally an undue burden of responsibility and care. So we've seen that on numerous occasions with quite young children exhibiting what we would call a role reversal in their relationship with their parents ... Ultimately that's very harmful for children because they're sacrificing their own needs. So some pseudo mature behaviour in a lot of these children is quite common, children five, six, seven looking after younger siblings and other little children as best they can because sometimes parents are not able to do that themselves.¹⁰⁶

A teenage Afghan girl told the Inquiry that:

My mum was sick always. She was very sad. Every night she was crying until one or two o'clock because we lost our father and she was crying. But now we are big and we look after her. My mum is always worried about the visa. Sometimes she has headaches.¹⁰⁷

One mother told the Inquiry of how her toddler attempted to comfort her when she was distressed:

... my friend got a psychiatrist to come in from outside to do an assessment and they give me a report. And having the report, I realised how stressed [my child] was, because she's taking the role, when I'm like upset, she's taking the role of the mother, she's comforting me and that is not for a [little child].¹⁰⁸

At Woomera, an ACM officer noted that the nine-year-old girl, described in the previous section on separation, was providing much of the care for her five younger brothers. She described the impact on the child as follows:

Resident [nine-year-old girl] is becoming increasing[ly] withdrawn, her attitude towards staff is becoming progressively more negative. She lacks a confidant[e] and has no effective outlet to express her emotions. She appears tired and depressed. She provides much of the fundamental child care needed for her 5 younger brothers and lacks the support she needs in order to effectively cope with such responsibility. It is my recommendation that these matters be reported to FAYS so that [she] may obtain the assistance she requires and be provided with an avenue of self expression external to ACM.¹⁰⁹

In another family, an 11-year-old boy was preoccupied with caring for his parents:

[the child] told me ... that he wanted someone to look after him as he was caring for both his mother and father himself. He said that he stayed up all night by drinking coffee so that he could keep watch over them.¹¹⁰

ACM informed the Inquiry that it had been greatly concerned about the mental health of this family for over 12 months and that:

Following exhaustive external psychological and psychiatric assessment, professional opinion unanimously declared that little could be done to help this family whilst they remained in the detention environment.¹¹¹

This family is discussed further in Case Study 1 at the end of this chapter.

9.3.5 Living in a closed environment

The environment in which a child lives is closely connected to their mental health. Children, parents, child protection authorities and psychiatrists all expressed concern to the Inquiry that the closed environment of the detention centre was detrimental to the mental health of children.

A last resort?

Many children and parents described to the Inquiry the impact of being surrounded by fences and razor wire:

I felt so bad staying in a place surrounded by razor fence. I can't understand and I always asked 'Why did they take me here?' ... It was scary.¹¹²

A father in detention said that the continuous locking and unlocking of gates sent the children 'crazy':

You should also realise that what kind, what a situation is going on with us. From the gate you came here, until here how many doors they opened for you? Is it humanity that they have made that many doors? They open and close, open and close. It's made the children crazy – mentally they are affected. Every day they go to the gate, they open the gate and close the gate and just the noise of those chains and the locks can make them crazy.¹¹³

Although the Inquiry heard evidence about the impact of the prison-like environment from all centres, the most consistent comments were regarding the new Baxter facility. One father said:

It is like a prison here. There is a fear in us when we see the cameras everywhere and the doors are all electronically opened. They only gave us a room with a toilet inside, like an ensuite. We don't have anything to have a good time with. It is only a land with grass and all around us there are rooms that other people live in. We can only see the sky and the grass.¹¹⁴



Family compound at Baxter, December 2002.

The Inquiry also received evidence about the impact of security practices at Woomera. In April 2002, the South Australian child protection agency described the security environment at Woomera as follows:

Centre staff controls all contact with the outside world, and movements, social engagement, religious practice, access to health care, and recreation within the facility. The constraints of security procedures ... results in much of the day to day control of detainee behaviour including that of children and young people within the facility resting with centre staff.¹¹⁵

In August 2002, DHS found that security needs at Woomera took priority over the needs of children:

The children at Woomera are living within an environment that is controlled and regulated. Most of the people they see are in uniform, including medical staff. The day-to-day administration of the centre is not flexible enough to minister to the needs of the children in any consistent way. **Security needs take priority over everything else.** ...

The major concern about the circumstances of children in this environment is that their needs are only addressed when possible, rather than as a matter of priority. The issues of centre security and safety of staff always take precedence, as one would expect within a detention facility. There is no argument with this.

However, it then follows that children within such a facility will never have their educational, developmental and emotional needs adequately met unless security and staff safety needs are compromised. This is the insoluble dilemma when children are held in a detention system designed for adults. [emphasis in original]¹¹⁶

A 2001 psychological study on the impact of long-term detention also described the security environment at Villawood, as intimidating:

The physical environment at Villawood is intimidating in a number of respects. Each compound is surrounded by multiple layers of high fencing topped and grounded by razor wire. All visitors must pass through high security checkpoints. Within the detention centre, there are multiple daily musters and nightly head counts, which may occur at 2am and 5.30am. The public address system, which operates almost continuously from 7am to 9pm, is also disturbing.¹¹⁷

The security environment is discussed in further detail in Chapter 8 on Safety.

9.3.6 Safety

The Inquiry frequently heard that children are particularly affected by witnessing violence in the centres. Chapter 8 on Safety discusses the threats to the safety of children in detention, including the exposure to violence, riots and self-harm including hunger strikes. This section considers the impact of that exposure on children's mental health.

A last resort?

The Inquiry heard expert evidence about the impact of trauma for children in detention. A psychiatrist who consulted and treated some children detained at Woomera told the Inquiry that witnessing violence can reactivate past trauma:

The other thing I would say is that one of the families that I spoke with in Woomera who are still in detention, it is not 5, 6 months, it is like 17, 18, you know, two years in detention. What had occurred for them was that witnessing the riots or the fires in Woomera and the experiences with the guards had actually reactivated for them experiences of war or trauma in their country of origin and they had believed, for example, that their parents were dying in the compound that was on fire and they felt unable to either get away from it or do anything. So there was a kind of exaggeration or re-activation of previous trauma.¹¹⁸

DHS described a child whose behaviour was severely affected by witnessing violence at Woomera:

Length of detention: 12 months. Parents expressed concern for their 3 year old. They believe that he is abnormal. They state that he is very active and has picked up bad habits from what he observes in his environment, including bad language, climbing and jumping, violence against himself and others and saying he wants to drink shampoo. They indicated they found him hard to control, which they attributed in part to the deprivation of normal parental responsibilities that occur in the centre. The child has begun wetting the bed again and sometimes screams in his sleep.¹¹⁹

Detainee parents also reported the impact of witnessing violence or severe disturbances on the psychological well-being of their children. The mother in a family detained at Port Hedland told the Inquiry:

The mental disturbance of our children happened since last May when the guards in uniform raided our home, our living quarters, and the children were asleep and when they woke up and realised that they have raided in, and with seeing that uniform, from then on they were very much disturbed.¹²⁰

A father from another family detained at Port Hedland reported that his 'children are impacted upon by this violence. It causes mental impact on them, mental disturbances'.¹²¹

The mother of a family detained at Woomera reported that:

Because children are for a long time detained in here and all the time they see a bad view like suicide, guard, batons, tear gas, bad things, abusing, insulting, so it's made the mentality of them so worse than before.

My little child and particularly this one, in midnight they are suddenly woke up and see bad dreams all the time he is stick himself with me, all the time he is sleeping with me, he get my hand 24 hours a day. In mid-night he woke up, screaming, always frightened, something when happen inside the compound, he is really afraid like, a day before yesterday, he was really scared and he is really depressed and not comfortable in here.¹²²

The Department stated that it:

is deeply concerned that children do on occasions witness violence. It makes every effort to prevent undesirable actions occurring and to ensure that children are not exposed to them.¹²³

9.3.7 Treatment by detention staff

The Inquiry received evidence that the manner in which children were treated by some detention staff caused distress to certain children. The evidence raises three specific factors:

- (a) disrespect shown to children by some detention staff
- (b) calling children by number rather than name
- (c) detention staff were not generally trained to work with children.

(a) Treatment with respect

Detention officers clearly fulfil a demanding role. ACM informed the Inquiry that:

The demands and behaviour of detainees can be extremely challenging, particularly when the reasons relate to detainee dissatisfaction with Government policy and Departmental decision-making.

ACM also reported that the majority of staff employed at Woomera were highly committed to assisting detainees, worked hard in difficult circumstances, and were often the target of detainee frustration with the processing of protection visa applications.¹²⁴

A psychologist who worked at Woomera for seven months during 2001 told the Inquiry that:

From my observation, staff generally treated children appropriately. Sometimes they were stressed, but I regarded them as doing their best for the main part.¹²⁵

The Flood Report also acknowledged the difficult task of detention officers and found that they were sometimes misunderstood by the Australian community:

The management of people in detention centres is an incredibly complex and important task. There are many dedicated Australians – nurses, doctors, detention officers, teachers, welfare counsellors, managers and public servants – helping in this process, often in remote localities, and sometimes encountering misunderstanding in the community for their part in administering policies determined by successive governments and laid down in relevant legislation. There needs to be greater public appreciation for the important and demanding work that they undertake.¹²⁶

A detention officer gave the Inquiry an example of the unnatural dynamic created by the detention environment. The officer explained that during large disturbances the children who were their friends the day before were suddenly throwing stones

A last resort?

at them. On the other hand, children would say that the officers that were their friends one day were standing opposite them in riot gear the next.

Thus, while the Inquiry accepts that most staff were doing their best to treat children appropriately, it is clear that there was sometimes a tense relationship between detainee and detainer.

A DHS report expressed concern regarding the attitude of some ACM staff towards children:

[T]he increased tension in the centre environment and the deterioration in the behaviour of some of the older children are factors that can deplete the ability of staff to maintain a balanced and compassionate attitude to the detainees in general and the 'difficult' children in particular. Some officers have managed to find this balance but others have not.

The general negativity about the detainees expressed by many officers would be an issue of major concern for management if it were occurring in, for example, a FAYS residential facility [for South Australian state wards].¹²⁷

One mother from Woomera told the Inquiry in January 2002 that ACM officers frightened her children:

Very bad treatment, they treat very bad, they frighten them. If the kids play, officers shout at them very loudly.¹²⁸

Another mother described the treatment as inhumane:

What I can say is that their behaviour and treatment of the children is not humane. Once he was hungry and I took him to ACM and said he was hungry. The ACM officer said, 'what can I do? If you want I can give my shoes for him to eat.'¹²⁹

The community organisation ChilOut described ACM staff throwing food at children:

On occasion, when children were given fruit, guards would throw the fruit at them, as if the children were animals, rather than hand it to them. On one occasion a guard threw an apple to an adult detainee. The detainee threw it back again and a fight broke out. A group of children witnessed this event and began throwing food at the guard.¹³⁰

Former detainee children provided another example regarding food:

Once a woman asked one of the boys to get her some milk for her small child. The boy went to an ACM officer who said, 'Sure you can have some milk', and tipped the whole bottle of milk out on the ground in front of him.¹³¹

The Inquiry also received evidence of ACM officers using obscene language when speaking to detainees. For example, the Port Hedland Department Manager's report for the final quarter of 2000 states that:

A number of allegations were received from several sources, including DIMA staff, that some ACM staff had used offensive language or were behaving in

a rude manner towards detainees. These matters were brought to the attention of ACM management for investigation and rectification.¹³²

An unaccompanied refugee child detained at Port Hedland during 2001 told the Inquiry that he learned English swear-words from detention officers:

One of the officers was swearing at me all the time, she was an officer from our area, she was continuously insulting us – I cleaned there – so I learnt all the words, didn't know any before. She called me 'dickhead', 'little bastard' and 'pimp' a lot, even to my brother 21 years old, she swore at him too.¹³³

The parents of three young boys at Woomera told the South Australian child welfare authority that:

[T]he boys have developed behaviours e.g. swearing, being aggressive to each other, which is inconsistent with the parents' values e.g. they say 'fuck' because (it is alleged) they have learnt from custodial staff.¹³⁴

A nurse employed at Woomera for more than 18 months from 2000-2002 described the derogatory language used by some ACM detention officers as follows:

Behaviour which was quite common, in fact almost every time a guard opened their mouth to speak to a detainee or to speak about a detainee, they would use derogatory remarks toward them, including the women and children. This included using words like 'scum, wog/s, cunt, little cunt, slut, trash, vermin, asshole/s, boaties, rezzies'. Not every guard spoke this way to [or] about the detainees, but many did, and this included speaking to them like this to their face and also in front of them as if they didn't exist (in the 3rd person).¹³⁵

This evidence is supported by the Flood Report that noted:

Credible witnesses have told me of derogatory remarks to detainees, humiliation of people in room searches and people sworn at in an abusive manner. I am satisfied on the basis of the credibility of these witnesses that these claims are valid. They apply to a small minority of detention officers.¹³⁶

ACM admitted the possibility that:

a small percentage of staff, do from time to time, display behaviours that are professionally unacceptable or that are not in accordance with the code of conduct. Where ACM is aware of such behaviour appropriate disciplinary action is taken.

ACM further informed the Inquiry that it:

understands institutional environments and the corresponding potential impact for some staff. This does not excuse or condone the type of behaviour described. Nor does this prove that this conduct was systemic or condoned by ACM.¹³⁷

A last resort?

(b) Calling children by number

The Inquiry received a great deal of evidence that children in detention have been called by number rather than name, and that this had a negative impact on them.

The *Government's Specific Responses to Flood Report Recommendations*, made in February 2001, stated that it was 'no longer practice in detention centres for ACM or DIMA staff to refer to detainees by registration numbers'.¹³⁸ However, during the Inquiry visit to Woomera in January 2002, the ACM Centre Manager advised, and the Inquiry observed, that all detainees at Woomera were referred to by number, not name.

A teacher who worked at Port Hedland in early 2001 told the Inquiry:

You know, there was a Christmas concert that was held in mid-December and I think some local church groups had donated some nice little presents for the children. And one officer stood up and started to call the children for their presents but called them by their numbers. And the ACM Centre Manager ... called this officer aside and said, 'Look we have visitors in the centre. You cannot call them by number. Call them by their names'. And the officer replied he didn't know what their names were. So the actual present giving ceremony was abandoned because they weren't aware of the names of the kids.¹³⁹

Unaccompanied children formerly detained at Curtin said the use of numbers made them feel 'like animals' and 'like you have a cow tag or something on you'.¹⁴⁰ Another child told Inquiry officers that 'they have made me forget that I have a name'. An unaccompanied child stated that:

I often asked myself and so did the others 'why did we come here?' ... My parents would regret their decision. ... I feel like I did something wrong, like I was being punished. ... Sometimes I feel like the ACM staff treated us like animals. They don't know how much my mother loves me. ... They yell for us to line up, do this, do that. They call you by your number.¹⁴¹

The Inquiry acknowledges that given the wide variation in the spelling of detainees' names, often within the same document or file, the use of numbers may well be good record-keeping practice. One father told the Inquiry that numbers were the only way to ascertain that detainees got the correct medication, and that nurses working with names only had given medication to the wrong person.¹⁴² However, it is a completely different matter when children, and the adults around them, are routinely addressed by a number rather than a name.

ACM acknowledged to the Inquiry that:

In some detention centres, a practice occurred of referring to detainees by number. When ACM Senior Management became aware of the practice, despite the explanation that this was the preferred address by some detainees or the practice resulted from an inability to correctly pronounce detainee names, directions were issued to cease the practice.¹⁴³

The Minister for Immigration and Multicultural and Indigenous Affairs (the Minister) acknowledged in April 2002 that children should not be called by name and referred to his direction that this should not occur.¹⁴⁴ During visits to immigration detention facilities later in 2002, the Inquiry observed that the practice of calling detainees by their numbers had ceased.

(c) Training on how to treat children

The Inquiry was concerned to determine whether ACM staff were appropriately trained and qualified for working with children. Although some of the professional staff have child welfare qualifications, the majority of ACM staff are 'Detention Officers' (guards) without specific training or expertise in working with children.

A qualified youth worker, employed at Woomera from May 2000 to January 2002, told the Inquiry that:

No training in child management was made available to staff upon employment in the centre. Some staff, such as myself, had experience and qualifications in relation to working with children, but others did not. One hour of our induction dealt with mandatory reporting requirements in relation to child abuse and harm. I regarded this training as inadequate.¹⁴⁵

Another ACM officer with child protection experience, employed at Woomera in 2000, said that:

Staff at [Woomera] were mostly from a prison background and not appropriately trained to care for children. They did not understand the developmental stages and psychosocial educational needs of children, or how best to talk with and manage them. It was apparent that many did not understand the cultures or experiences of these particular children and no training was given to help them deal with these issues.¹⁴⁶

In August 2002, the Perth detention facility conducted a refresher course on 'Children in Detention'.¹⁴⁷ While this is a welcome development, it is hoped that the training will also occur in facilities where children are normally detained.

9.3.8 Findings regarding the factors leading to mental health and development problems for children in detention

It is no secret that the institutionalisation of children increases the risk of mental health problems.¹⁴⁸ Evidence from current and former detainee children and their parents, former ACM medical staff, Department Manager reports, State child protection agencies, State mental health agencies, independent mental health experts, torture and trauma services and community groups involved with current and former detainees all confirm the detrimental impact that long-term detention of children has on their mental health.

While there are a number of factors that contribute to the mental health problems found in children in detention, all of those factors are either a direct result of, or exacerbated by, the long-term detention of children and their families.

A last resort?

In no particular order of importance, some of the important factors that can contribute to the mental health and development problems of children in detention include:

- prior torture and trauma
- the length of detention
- uncertainty and negative visa outcomes
- breakdown of the family unit
- living in a closed security environment
- exposure to violence.

Pre-arrival experiences of torture and trauma can have a significant impact on the mental health of child detainees. However, mental health experts have found that at best long-term detention 'exacerbates' those conditions and at worst it 'out-strips' that past trauma.

The Department, ACM, mental health experts and children themselves agree that the longer the period of detention the more likely it is that children will have mental health issues.

Negative visa outcomes impact on the psychological well-being of children and their parents in two ways. First, it leads to uncertainty and disappointment about a family's future in Australia. Second, it leads to a longer time in detention. The combination of factors magnifies the impact of each.

Long-term detention also has a significant impact on the family unit. Case Studies 1 and 2 at the end of the chapter, and the examples discussed above, demonstrate how serious this problem can be. Detention not only takes away the normal family environment where parents have autonomy and control of the day-to-day life of a child, it can have a serious impact on the mental health of parents. These factors diminish the supportive role that parents would normally play for their children. In some cases this has led to role reversal, with children inappropriately taking on the supportive role. In other cases the poor mental health of one or more parents has resulted in hospitalisation, medical observation or security separation. This has led to separation of children from their parents. While efforts have been made to provide opportunities for contact, the separation has exacerbated the stresses already facing children.

A living environment whereby children are surrounded by fences, razor-wire, locking and unlocking gates and detention officers has also impacted on children as has the violence that sometimes erupted around them.

The Inquiry has not received evidence suggesting a systemic and direct link between the treatment of children by detention staff and mental health concerns – in particular, children – and therefore finds that this was not a primary cause of the mental health problems found in children in detention. Nevertheless, while detention officers worked in difficult conditions, and while most detention staff did their best to treat children appropriately, some did not treat children with the respect that they deserved. Several children and parents described the inappropriate language that they had learned

from detention officers. Until 2002, staff in some detention centres referred to children by number rather than name, which has a dehumanising effect on children. The Inquiry has not received evidence that detention staff received training regarding the treatment of children other than in August 2002 in the Perth detention facility (where no children are detained).

9.4 What was the nature and extent of the mental health and development problems suffered by children in detention?

The Inquiry received evidence regarding the range of mental health problems suffered by children from a variety of sources, including individual psychiatric reports on children in detention, reports from State mental health agencies who treated children in detention and psychiatric studies regarding children in detention. All of these sources indicate that some children in detention have experienced significant mental health problems, particularly those children who have been detained for lengthy periods of time. Some of those problems were diagnosed mental illnesses and others were more general problems affecting the psychological well-being of children in detention. At the same time, the Inquiry acknowledges that many children, particularly those detained for shorter periods of time, did not suffer significant harm to their mental health.

The Inquiry has not attempted to draw precise conclusions regarding the statistical prevalence of mental illness caused by the detention experience. However, there have been several recent studies conducted by psychiatrists and psychologists in Australia which have examined the impact of detention on the mental health of sample groups of child detainees. The South Australian child protection and mental health authorities have conducted several assessments of children in Woomera over 2002. Those assessments suggest that the prediction of the Alliance of Mental Health Professionals regarding the adverse impact of detention on children's development, psychological and emotional health was correct (see section 9.3).

For example, a study of 33 detainees at the Villawood detention centre in 2001 describes the range of psychological disturbances experienced by children in detention as follows:

A wide range of psychological disturbances are commonly observed among children in the detention centre, including separation anxiety, disruptive conduct, nocturnal enuresis, sleep disturbances, nightmares and night terrors, sleepwalking, and impaired cognitive development. At the most severe end of the spectrum, a number of children have displayed profound symptoms of psychological distress, including mutism, stereotypic behaviours, and refusal to eat or drink.¹⁴⁹

A more recent study of the mental health of children in detention was completed in early 2003 by health professionals from five institutions (the 2003 Steel Report). The study considered 20 children from the same ethnic background in a remote detention centre between 5 September 2002 and 13 February 2003. The average

A last resort?

period in detention of these children was 28 months. The study found that all 20 children were suffering from psychiatric illness:

All but one child received a diagnosis of major depressive disorder and half were diagnosed with PTSD. The symptoms of posttraumatic stress disorder experienced by the children were almost exclusively related to experience of trauma in detention. Children described nightmares about being hit by officers, and many of the children (13, 65%) were described by their primary caregiver as having episodes where they would scream in their sleep or wake up shouting.

Half of the children manifested separation anxiety disorder, whilst the majority of other children experience persistent symptoms of separation anxiety but at a level that did not warrant a diagnosis of this disorder.

Over half of the children in the target age group for enuresis (5 to 12 years of age) suffered from the disorder, regularly wetting themselves three or more times a week. Almost half the children assessed had developed behaviour consistent with a diagnosis of oppositional defiant disorder. More than half of the children regularly expressed suicidal ideation, many thought it would be better if they were dead and made statements such as "there is no point in life, one must die, I wish I was not in this world." A quarter (5) had self-harmed either by slashing their wrists or banging their heads against walls (2).¹⁵⁰

The authors of this report acknowledge the small sample group but note that this was 'an almost complete population of detained families (10 or 11 families) from one language group in a single detention facility'. They find a clear link between detention and mental health with the level of psychiatric illness in those children increasing tenfold over the period of detention.

The reliability of this study has been criticised by both the Department and ACM. The study itself recognises its strengths and weaknesses in coming to its findings and the Inquiry has taken these into account in assessing it.¹⁵¹ The Inquiry notes, however, that the findings of the study are consistent with the findings and observations of a range of other experts about the impact of detention on asylum seekers. For example, a recent study from the United States finds that prolonged detention has a lasting negative mental health impacts on detainees.¹⁵²

Other experts have also reported mental health problems in detainee children, particularly those who have been detained for lengthy periods of time. For example, the CAMHS summary report regarding 14 children and their families referred from Woomera, between January and July 2002, provides an overview of the kinds of mental health problems experienced by children in detention.¹⁵³ The summary

presents a disturbing picture of the mental health of certain children detained at Woomera during this period of time:

Summary of Children and Families in Woomera IRPC Referred to and Assessed by Child and Adolescent Mental Health Services, January to July 2002

Children under 5 years: These 4 children aged 11 months, 2½ and 3, 3½ years have all spent at least half their lives in immigration detention. They present with various symptoms related to exposure to violence and chronic parental depression that include delay in expected milestones, particularly language and behavioural regulation (including continence). One has phobic symptoms related to exposure to riots in the centre.

Children aged 7 to 17: 10 children (mean age 12.9 years): A decision was made to include pre adolescent children in this section of the report because of their very similar presentations. **The severity of symptoms related to thoughts of, and actual self harm in preadolescent children is extremely unusual in other populations, and very concerning.**

1. All of these children expressed recurrent thoughts of self harm. At least 7 of the 10 children have acted on these impulses, cutting or hurting themselves, attempting to hang themselves, drinking poisons or refusing food for many days as a suicidal act. At the time of writing, self destructive behaviour amongst this group of children has escalated to daily cuttings, hanging attempts and provocation of conflict with ACM staff, which can in itself be understood as self destructive.

2. All were troubled by intrusive memories and thoughts of adults, including their parents, self harming. This included graphic witnessing of attempted hangings, slashings and self-poisoning. Most fulfilled criteria for a diagnosis of post traumatic stress disorder [PTSD]. Some also reported intrusive memories of traumatic events prior to arriving in Australia.

3. All reported a sense of futility and hopelessness, for some this was predominantly associated with anger, (including current acting out and provocation of ACM staff), for others despair and withdrawal. All were troubled by recurrent thoughts of death and dying. Those who have not yet self harmed reported feeling afraid they would be unable to stop themselves repeating the behaviour witnessed in the adults.

4. All had trouble sleeping, reported poor concentration, little motivation for school and overwhelming boredom. Most had lost weight. All fulfilled criteria for major depression with suicidal ideation. Several also have significant phobic or generalised anxiety symptoms. These are associated with anxiety about their parent's survival or traumatic experiences with ACM staff.

5. All reported anxiety about their parent's well being. All have parents who are significantly depressed and may have attempted, certainly expressed suicidal ideation. One has seen his father psychotic and dancing naked in the camp. Another mother cut herself and wrote on the wall in her blood. All parents have been assessed or treated for depression and PTSD (several had been psychotic).

6. Many of the children were being required to assume roles and responsibilities of adults because their parents were unable to do so because of their own ill health. An example is an 11 year old girl with several siblings under 5 who is doing most of the parenting for her siblings as mother and father are unable to do so. Another example is an 11 year old boy left to care for his 3½ [year old] brother during many weeks while their mother was in Woomera hospital with psychotic depression. They were notionally in the care of their estranged father. This boy was sexually assaulted and harassed by other men in the camp during this time. There were few options available to keep him safe while his mother remained unwell.

A last resort?

7. All the parents expressed considerable guilt and despair about bringing their children into this traumatising and hopeless situation. Some of them express a wish to die in the belief their children may fare better without them. One believes god is calling her and her son to die...

While each family has particular issues and difficulties, an overwhelming feature of the assessments was the clear evidence of the detrimental effects of the detention environment on the children both directly, (including inadequate developmental opportunities, exposure to violence and adult despair and removal of hope for their futures), and indirectly, as a consequence of parental mental illness. [Emphasis in original]¹⁵⁴

A further psychiatric study considers 10 consecutive referrals to CAMHS between February and August 2002.¹⁵⁵ In this study, information obtained in a series of detailed clinical interviews undertaken by a range of experienced mental health professionals during 2002, was used to develop consensus diagnoses on each individual child and adult assessed. The study included ten families, including 16 adults and 20 children aged from 11 months to 17 years, and represented approximately half of the children detained in the centre at that time. Following is a summary of the study's main findings:

Children under five-years-old (ten children):

- Five (50 per cent) presented with symptoms including delays in language and social development and emotional and behavioural dys-regulation.
- Three (30 per cent) showed marked disturbance in their behaviour and interaction with their parent or carer, indicating disturbances or distortion of attachment relationships.
- Over time a further three children in this age group were diagnosed with severe parent-child relationship problems, particularly oppositional behaviour and separation anxiety.

Children aged six to 17 years (ten children):

- All fulfilled criteria for post traumatic stress disorder.
- All were troubled by experiences since detention in Australia. One also reported troubling thoughts about events on the boat to Australia as well as experiences in the detention centre.
- All reported trouble sleeping, poor concentration, little motivation for reading or study, a sense of futility and hopelessness and overwhelming boredom.
- All fulfilled criteria for major depression with suicidal ideation.
- Three (30 per cent) reported frequent nocturnal enuresis since being in the detention centre.
- All reported recurrent thoughts of self-harm. Eight (80 per cent) had acted on these impulses, including three pre-adolescent children.
- Seven (70 per cent) had symptoms of an anxiety disorder.
- Half (50 per cent) reported persistent severe somatic symptoms, particularly headaches and abdominal pain.

Family impact – parental mental illness:

All children had at least one parent with a major psychiatric illness. All had seen adults self harm, often their parents. In both sole parent families the parent had been hospitalised with a psychotic illness leaving children alone in the camp. During this period, four parents required psychiatric hospitalisation.

On the other hand, while ACM acknowledged that the 'assertion that detention has an impact on detainees ... simply reflects the findings of at least three decades of research,' it has also submitted that there was an 'extremely low' incidence of mental health problems regarding the 81 children in detention as at July 2003 (excluding the Woomera Residential Housing Project). ACM submitted that, having reviewed the medical records of all 81 children, only 6.2 per cent of children were suffering from depression, 1.2 per cent were suffering PTSD and 12.3 per cent were suffering developmental delay. ACM has asked the Inquiry to consider the review as 'the most accurate and compelling information available to the Inquiry'.¹⁵⁶

There are, however, a number of problems with the claim made by ACM as to the incidence of mental health problems and the information upon which it is based. First, ACM's statistics focus on those children for whom there has been a medical diagnosis of 'developmental delay', 'clinical depression', or 'post traumatic stress disorder'. The CRC requires a broader consideration of mental health. For example, problems like anxiety, distress, bed-wetting, suicidal ideation and self-destructive behaviour, which are noted in the studies cited earlier, are relevant to an examination of whether children have enjoyed the highest attainable standard of health and the maximum possible opportunities for development.

Second, the primary records before the Inquiry suggest a higher incidence of mental health problems than is acknowledged in the information provided by ACM. The Inquiry has identified discrepancies in evidence regarding five children about whom the Inquiry has detailed records.¹⁵⁷ This raises concerns about the overall reliability of the ACM review.

Third, the figures relied upon by ACM did not include children in the Woomera Residential Housing Project (RHP). The documents before the Inquiry indicate that at least three children detained there in July 2003 had been diagnosed with depression.

The Inquiry also notes that, to the extent that the information presented by ACM may be said to reflect the incidence of mental health problems for children generally over the period of the Inquiry, that information is at odds with the weight of evidence provided to the Inquiry. For example, State mental health experts and ACM medical staff report higher numbers of children suffering from these disorders, as discussed below.

Considering the weight of evidence before the Inquiry, the Inquiry has concluded, on balance, that it should not rely upon ACM's assessment of the mental health of children in making a general conclusion as to the extent of mental health problems for children in detention.

A last resort?

However, as stated earlier, the Inquiry has not sought to determine the exact statistical prevalence of mental health problems because, irrespective of the total numbers of children who have suffered mental health problems as a result of detention, human rights are designed to protect each and every individual. To the extent that the detention of any child prevents that child from enjoying the highest attainable standard of health or an environment that fosters their rehabilitation from past torture and trauma, there may be a breach of international law. Therefore, while the Inquiry is concerned by the studies suggesting relatively high numbers of children in detention with mental health problems, the exact figures are not important.

The evidence the Inquiry has received from mental health experts who have examined children in detention centres is set out below. That evidence suggests a strong link between detention and incidences of developmental delay, depression and PTSD.

There is also evidence suggesting that the Department understood the connection between prolonged detention and increasing mental health problems for children. For example, the May and June 2002 Department Manager reports from Woomera note that there is '[c]ontinued focus on a number of families whose reactions to long term detention demand increasingly frequent health service and psychologist attention'.¹⁵⁸ Each of these reports attaches a list of individuals with significant mental health needs.

Further, all incident reports are forwarded to the Department's head office and every kind of self-harm is classified as an 'incident' that should be reported by ACM to the Department. In addition, most correspondence with child welfare agencies and agencies like CAMHS was with the Department, thus the connections between the length of detention and mental health of children must have become increasingly obvious over 2002.

9.4.1 Developmental problems

The Australian Association for Infant Mental Health told the Inquiry that recent research demonstrates the crucial importance of a child's environment during their first few formative years.¹⁵⁹ Dr Louise Newman of the NSW Institute of Psychiatry described how the detention environment might contribute to developmental delay in young children:

These very young children are showing signs of developmental delay and very severe attachment problems and ... there is quite a significant body of research and scientific evidence which points out the very severe and complex developmental problems that can result from these sorts of early disturbances. There is also a body of literature which we have made reference to which points out how vulnerable children are to these sorts of very distressing experiences and the trauma they are experiencing particularly in terms of their neuro-biological development, their brain development and then again I think both these bodies of evidence point to the fact that we are going to have long term problems, potentially, for these children.

These are children who even if they are very young, are witnessing extremes of disturbed behaviour in adults. They frequently have parents who themselves are traumatised, distressed and despairing who are unable to parent effectively in the detention context. The developmental effects, I think, are added to by the depriving and harsh nature of the environments with very clearly inadequate opportunities for play, for exploration for learning and other crucial experiences that children need if they are to develop normally.¹⁶⁰

DHS, whose staff visited Woomera and spoke to children on several occasions, also expressed concern about the impact of detention on development:

Children and young people have a range of developmental needs including physical activity, competence and achievement, self-definition, creative expression, positive social interactions, structures and clear limits, and meaningful participation. The ability to meet the developmental needs of children is greatly compromised in the artificial and restricted environment of a detention centre.¹⁶¹

A senior child psychiatrist who examined a family in Woomera in May 2002, made similar comments:

Before outlining my assessments of the children, I wish to comment on the detention centre environment, as it impacts on any of the 40 or so children currently resident there. Staff reported to me that children who are in the centre for long periods manifest a significant regression over the period of detention. In my opinion, many factors contribute to this regression, over and above the issues within individual families. These factors include: cognitively impoverished conditions, with little opportunity for play and legitimate academic pursuits; reduced availability (physical and emotional) of attachment figures; interference with normal family rituals of feeding and caring; lack of privacy; hostile and deprived physical environment with intimidating and ever-present security measures; dehumanising use of numbers rather than names (theoretically now banned, but highly prevalent during my visit); and exposure to violence (not only witnessing intermittent full scale riots, but also equally disturbing episodes such as men burying themselves and inviting their family to sit around and watch them die). It is hard to conceive of an environment more potentially toxic to child development.¹⁶²

A doctor who worked at Woomera in both August 2001 and January 2002 gave an example of serious developmental delays in an infant:

There was a specific example that I can give you of an infant who had been born in detention in early March 2001. I saw him when he was six months, five/six months of age, in August. He was developmentally delayed then, I believe, in that he was not rolling, for example. Very little babble. But what struck me much more was on revisiting the centre in January, where this same infant had not yet learnt to crawl, could barely sit upright by himself, was still not babbling and showed features of quite significant developmental delay for a one-year-old.¹⁶³

A last resort?

The Inquiry also heard of developmental speech delay in child detainees, often directly related to the impact of the detention environment. For example, parents worried about babies crying because of the possibility of waking others when many families shared accommodation. One family with a young child told the Inquiry that:

My son is [a toddler] and his speech development is late because of the situation in the dongas ... we don't have privacy and every time he try to say something, at night especially I say ['don't'] because the people would wake up or they would swear ... if the child shout and this sort of things, so he's got a speech development [problem], in the [day], he doesn't talk much.¹⁶⁴

In another example, a mother detained at Woomera told the Inquiry that her young son developed a speech impediment and started bed-wetting because of the trauma he felt after an intrusive headcount by officers in riot gear:

With the special clothes, when it's a search going and they have some special clothes wearing, they came at night-time yelling and screaming for them to wake up, with their batons. Then after that, our son has [started] stammering, and then at night-time he wets, you know, bed-wetting, and so from that time onwards I have to put nappy on him when he goes to bed.¹⁶⁵

The following case study was described by DHS in April 2002.

CASE STUDY: Child development

Extract from the Department of Human Services Woomera Detention Centre Assessment Report, 12 April 2002

Length of detention: 12 months. The parents reported concern about the development of their 3 year old child stating that his early childhood development was normal and that they were unconcerned about the child during the first one and half months in detention. After that time they became concerned about the child's behaviour as he became increasing[ly] exposed to violence and swearing. Observed behavioural changes included: swearing, aggression, fighting with peers, sleep refusal, night time waking and crying, destruction of toys, refusal of food.

The mother was separated from the child for over a month during her last confinement. This resulted in an escalation of his behavioural problems.

Parents report they have been to the medical centre on numerous occasions for their concerns but these have not been investigated. The child eats only small amounts of food at meal times. Parents are not permitted to take food from the dining mess to offer between meals. Rooms are searched for food. Parents state that they do not have access to play activities or suitable educational toys.

The parents report concern for the baby (8 months). To date the child has not received routine vaccinations (verified). The mother experiences delays in obtaining formula through the medical centre and baby food is not readily accessible. ...

Assessment Observations: ... On the basis of observations with this family there is concern for the mental health of the parents, the behavioural problems exhibited by the 3 year old, the listlessness and under stimulation

of the baby, and the diminished capacity of the parents to respond to the nurturing of either child. The parents are trying to manage under difficult circumstances. Both parents need to be able to respond [to] the total nurturing requirements of their children in better living facilities. They require access to games, toys and other resources that will promote their relationship with their children and stimulate the cognitive and general development of their children.¹⁶⁶

In another case described in the same report, DHS makes observations about a family with a two-year-old and a baby:

Assessment observations: Both children's physical and developmental needs are not being adequately met in the centre. This is influenced by the environmental factors/restraints and lack of access to resources. The eldest child (2 years) developmental milestones appear to be on the border of age-appropriate. The baby is at risk of not meeting specific milestones in regard to gross motor development and speech due to lack of safe areas to explore and stimulation. The nutritional needs of the children are not being met, there is no adequate educational material on diet available and it is not possible for toddlers to have age appropriate small and frequent meals. This places both children at risk of poor growth and nutritional imbalance. Both children are at risk of cumulative harm in regards to normal growth and development because of the current environmental conditions and the lack of age-appropriate resources.¹⁶⁷

This evidence indicates that the detention environment can have, and has had, a negative impact on children's development. This is a matter of concern to the Inquiry.

9.4.2 Depression and post traumatic stress disorder (PTSD)

The evidence provided to the Inquiry by State child welfare authorities who examined children in the centres, doctors employed in the centres and the 2003 Steel Report suggest greater numbers of children suffering from depression and PTSD than indicated by the figures cited for July 2003 by ACM. These experts consistently make a link between detention and the occurrence and severity of these illnesses – whether it be because detention triggered the illness, exacerbated the seriousness of the illness or inhibited the ability to appropriately treat the illness.

(a) Detainee reports

Child detainees and their families repeatedly told the Inquiry of the impact of detention on their mental health, particularly leading to depression. While not all these detainees will be talking about 'clinical depression', the following quotes indicate the declining psychological well-being of children from their parents' point of view.

The father of children detained at Curtin said of his children that:

Also they have anxiety and they are under extreme depression because every day they just look at the security wire and getting frustration and also some of them like my children they get cutting their bodies by broken glass. They are just moving around the fence and shouting that we need the freedom.¹⁶⁸

A last resort?

Another father said that his son 'had suffered from the fact that they couldn't go outside, and he has developed some kind of depression'.¹⁶⁹ Yet another father reported that his daughter 'is suffering from depression, my daughter is chewing her teeth whilst asleep and also [passed] her urine while asleep'.¹⁷⁰

A father detained at Woomera described how his son had to go on medication for depression:

FATHER: Doctor gave him anti-depressant medication for a while, to [my son], and it didn't work. Not only didn't help, it just makes, makes his eye and makes his vision getting worse somehow, it's more blinking now that he used to do before.

INQUIRY: So, what do you think the solution is?

SON: I need help.

INQUIRY: What kind of help do you need?

SON: I should go out.¹⁷¹

When the Inquiry visited Baxter in December 2002, a higher percentage of detainee children and their parents reported they were depressed than during any other Inquiry detention centre visit.¹⁷² Almost all of these families had been in detention for well over a year. One mother described the state of her son as follows:

Actually my son is very depressed and is very nervous. We can't talk to him basically. He doesn't take shower, he doesn't brush his teeth, he smells very badly and when I tell him he tells me get out of here I don't want to talk to you. I can't talk to him, when I talk to him all my body shakes. I'm just worried he'll do something to himself. ...

For myself because of the stress I have all sorts of problems. I can't eat food, I only eat a bit of salad ... We will stay here until we die, we don't have anywhere else to go back. Our healthy family is now shattered, we are all sick.¹⁷³

Another mother from Baxter said that both she and her daughter were depressed:

Myself and my daughter because we were depressed and [the psychologist] said he can't do any for us except freedom is our only solution. My daughter, she has nightmares, she bites her nails, she fights all the time with her sister and she's very nervous and very depressed.¹⁷⁴

(b) Expert mental health reports

The 2003 Steel Report regarding 20 children in a remote detention centre found that '[a]ll but one child received a diagnosis of major depressive disorder and half were diagnosed with PTSD'.¹⁷⁵

This evidence is supported by the South Australian CAMHS report that finds, of the ten children aged between seven and 17 who were assessed between January and July 2002, '[m]ost fulfilled criteria for a diagnosis of post traumatic stress disorder' and '[a]ll fulfilled criteria for major depression with suicidal ideation'.¹⁷⁶

Depression in children was also noted by medical staff from detention facilities. A nurse who worked at Woomera told the Inquiry that depression was particularly evident amongst children who had been in detention for an extended period of time:

My main observation is that the children are very, very much – very subdued, almost – they were almost at a state of emotional numbness. I found that just by walking through the camp, I often found that they would not even make a noise when they were playing and they just appeared ... developmentally retarded.¹⁷⁷

A paediatric registrar who worked at Woomera in both August 2001 and January 2002 told the Inquiry that:

... in one day, on 10 January [2002], out of probably about 20 people that I saw, 14 of the children displayed symptoms of post traumatic stress disorder. These were a variety of children from only a few months of age to 16 years of age. Their symptoms include withdrawal, behavioural change and a common feature is bed wetting, which was very commonly seen in the camp.¹⁷⁸

This doctor also noted that many parents were worried about their children's depression:

Many of the parents were concerned that they could not support their children or do anything about the problems of the withdrawn behaviour or the destructive behaviour or the nocturnal enuresis. And they found it particularly frustrating and worrying, of course, for their children that they were becoming very depressed.¹⁷⁹

She told the Inquiry that treating depressed children was extremely difficult:

Under normal circumstances one would provide immediate access to counselling, as it were, to simply talk to children, to change an environment. If it is the environment causing the stress or the depression, one of the first things to do is to try and improve the environment or to support the environment under which the child must live, to support the parents. Sometimes children go on to medication, not often. We usually try and provide the optimal and maximal physical support in the environment.¹⁸⁰

She said in some cases she took the extreme step of putting children on anti-depressant medication as this was the only option in the circumstances of the detention centre.¹⁸¹

A November 2002 report by an ACM psychologist noted depression and PTSD amongst children detained at Woomera continued to be a problem:

[Girl, aged 14 years]

Diagnosis: [Girl] has persisting symptoms of major depression and posttraumatic stress disorder despite several months of treatment with therapy and appropriate medication. She is actively suicidal.

[Boy, aged 11 years]

Diagnosis: [Boy] is completely dysfunctional for his age and experiences bouts of depression and uncontrollable rage. He is in the process of developing borderline conduct traits. High risk of suicide.

A last resort?

[Girl, aged 17 years]

Diagnosis: [Girl] has symptoms of major depression and posttraumatic stress disorder. Despite appropriate medication her symptoms persist.

[Boy, aged 4 years]

Diagnosis: [Boy] has regressed and developed anxiety symptoms and enuresis. His speech may also be delayed. He has significant cognitive developmental problems and displays behaviour that is consistent with a diagnosis of Oppositional Defiance Disorder.

[Girl, aged 3 years]

This young girl has spent almost a third of her life in detention. Some of her nightmares may indicate the gradual development of post traumatic stress disorder from the inappropriate events that she may be witnessing.

[Boy, aged 14 years]

[Boy] meets criteria for major depressive disorder. [Boy] is in a very vulnerable phase of self development and in addition to the significant suicidal risk, there is a significant risk of a destructive erosion of his sense of self.

[Girl, aged 12 years]

[Girl] meets criteria for major depressive disorder with significant anxiety symptoms. Of more concern is the regressive, disintegrative behaviour and the development of significant emotional numbing. [Girl] is significantly impaired.¹⁸²

Further examples of children suffering from depression and PTSD are described below and in Case Studies 1 and 2 at the end of this chapter.

(c) Case examples of depression and post traumatic stress disorder

The following examples are just a few case examples of the several that could have been provided from the documents available to the Inquiry.

Example one

The first example is of a 13-year-old boy who is discussed in the South Australian Department of Human Services Woomera Detention Centre Report of April 2002. At that time the boy had been detained for 455 days:

Assessment observations: The 13 year old is very withdrawn and lethargic. Since entering Woomera he has been suicidal and very sad. He reports nightmares nightly, seeing himself dead, or unable to move with people carrying his body. He reports waking screaming and finds trouble falling to sleep. He reports a diminished appetite. He has little memory of past events and no hope for the future. He refuses to make new friends because he believes they will be released but not him. He engages in constructive day time activities but spends hours sitting staring vacantly. TSCC test score confirm he has a depressive disorder and probably Post Traumatic Stress Disorder.¹⁸³

Example two

The second example is of 13 and 14-year-old brothers who had been in detention for 15 months in April 2002.

An ACM psychological report on the elder boy from December 2001 reported the following:

He is suffering deep depressive symptoms which are steadily increasing, along with the depression now infecting his family. He and his family have tried vainly to manage their distress, but it seems they are at a critical point which is more difficult to control than previously. [He] is a teen-age boy with needs of freedom and security, neither of which are available to him. He has clearly suffered traumatic periods in his life and aligns these early experiences with his present state, which he views as imprisonment.¹⁸⁴

In April 2002, DHS made the following comments about this child who had, at that point, been in detention for 435 days:

ACM medical records confirm the mother and second eldest child have experienced depression. Both the eldest and second eldest child exhibit symptomatology consistent with post-traumatic stress disorder.

Assessment Observations: A DHS psychologist administered the TSCRA self measure for post-traumatic distress on the eldest child, the profile reflects a depressive disorder and in all likelihood is reflective of Post-Traumatic Stress Disorder. When administered on the second eldest child the responses produced elevated scores on the Anxiety Depression and Over Dissociation sub-scale. This is likely to be reflective of a depressive disorder. Both young men require psychotherapeutic follow-up. Both have attempted suicide on more than one occasion and self-harm.¹⁸⁵

In September 2002, The Flinders Medical Centre reported that the 14-year-old:

... presented as an insightful, perceptive and burdened young person whose thoughts and feelings about his protracted detention in Woomera had become all encompassing. The overwhelming picture of himself conveyed ... was one of sadness, grief and a disbelief that he could be perceived as someone bad enough to be incarcerated for such an extensive period of time. Not surprisingly, [his] presentation and what he said about his thoughts and feelings including his disturbed sleeping patterns, his preoccupation with self-doubt and self-harm were consistent with the symptoms of depression. ...¹⁸⁶

Regarding his younger brother:

[He] too, presented as an insightful young person similarly well able to convey the extent of his unhappiness. [He] was aware of the ongoing impact on him of continued detention and of witnessing and experiencing the despair and missocialising influence of other adult persons detained in Woomera Detention Centre. [He] too, remains in a situation that is destructive of his developmental capabilities and his physical safety cannot be secured while he remains in detention.¹⁸⁷

Example three

The third example is of a 13-year-old boy and his 11-year-old sister. A senior child psychiatrist examined the children in May 2002, after the children had spent more than a year in detention, and made the following diagnoses:

A last resort?

[The brother] meets criteria for major depressive disorder. More importantly, he is an acute and serious suicide risk. [His] suicidal intent is closely related to whether or not he is in detention. This should not be dismissed as some form of emotional blackmail, but recognised as a realistic reaction to his appraisal of his predicament after many months in detention witnessing the progressive disintegration of his family, and the destruction of hopes for the future. ...

[The sister] meets criteria for major depression with significant anxiety symptoms. Of more concern is the regressive, disintegrative behaviour (as manifest by her paper tearing) and the development of significant emotional numbing (as manifest by her statement 'my heart has become hard'). Like her brother [the child] is significantly impaired and her psychological condition cannot be properly treated within the detention environment which is itself a major contributing factor.¹⁸⁸

This boy's involvement in self-harm activity is explored in Case Study 3 at the end of this chapter.

Example four

A comprehensive consideration of a case of PTSD in a detainee child is found in the case study regarding Shayan Badraie at the end of Chapter 8 on Safety. Shayan was detained at Woomera in March 2000. After he had witnessed an adult detainee threaten suicide in November 2000, he began exhibiting signs of PTSD. He and his family were transferred to Villawood in March 2001, where following further exposure to traumatic incidents, the child continued to exhibit signs of the disorder. He was hospitalised eight times between May and August 2001 when he was finally transferred into foster care detention in the community.

In 2002, the Human Rights and Equal Opportunity Commission (the Commission) investigated a complaint made by Mr Mohammed Badraie on behalf of Shayan regarding his treatment by the Department. The Commission concluded that the Department had breached the CRC. Full details of this case are contained in the case study at the end of Chapter 8.

9.4.3 Self-harm

The Inquiry was presented with numerous examples of self-harm by children in immigration detention centres, particularly amongst longer term detainee children since January 2002. Most of these children were also suffering from depression or PTSD. The extent of self-harm amongst these children is illustrated by CAMHS findings regarding children aged between seven and 17 who were detained in Woomera between January and July 2002:

All of these children expressed recurrent thoughts of self harm. At least 7 of the 10 children have acted on these impulses, cutting or hurting themselves, attempting to hang themselves, drinking poisons or refusing food for many days as a suicidal act.¹⁸⁹

The Inquiry also heard that witnessing self-harm amongst other detainees has a significantly detrimental impact on children and in some cases contributed to their own attempts at self-harm.

This section describes (a) the impact on children of witnessing self-harm, and (b) the prevalence of self-harm amongst children, including several examples.

(a) Exposure of children to self-harm by others

Children in immigration detention have been exposed to a large number of self-harm incidents. For example, a psychologist who worked at Woomera in early 2002 told the Inquiry:

The self harming was so prevalent and so pervasive that no child would have avoided seeing adults self harming. ... There was very visible self-harm, constant talk of it. The children for example when I arrived would have seen people in graves – when I first arrived there were people in dug graves with children seeing this. Some of the children – it was their parents or people they knew. They knew why the parents were doing this. They knew that the parents were talking about possibly dying. They were on a hunger strike. There was visible self harming on the razor wire. People were taken to the medical centre at regular intervals having slashed. People taken to hospital. There were attempted hangings that these children would have seen.¹⁹⁰

Current and former child detainees reported witnessing self-harm. For example, children interviewed in Curtin in June 2002 described cutting:

One day somebody was cutting himself, cutting his chest around, abdominal, and near the Gulf gate, which is the main gate to main compound. All the children was looking.¹⁹¹

Refugee children formerly detained at Woomera also told the Inquiry of being exposed to self-harm. A 14-year-old boy said that he had witnessed someone cutting his stomach with a knife in the kitchen.¹⁹² Another child said that during protests (with everyone shouting 'visa, visa' outside), a man cut his own throat in front of his wife and children inside the toilet block.¹⁹³ Refugee children formerly detained at Port Hedland described a man who threatened to jump off an electricity pole:

I saw a person who had been in Port Hedland for nearly three years, he climbed an electricity pole. He was there from the morning until night. He wanted to kill himself. He wanted to jump. The officers said you can't do this. He said 'why can't I go out?'. He didn't have any food or drink. He was crying. He wanted to jump and the officers put mattresses on the ground, and then they got a cherry-picker and got him down. He didn't want to go. He was fighting with them. I was watching this and I was crying. My sister still has dreams. She was five. I was scared.¹⁹⁴

In April 2002 DHS reported that exposure to self-harm has serious mental health consequences:

For the children and young people in Woomera their continuous exposure to violence and self-harming behaviours is also creating an unstable and

A last resort?

unsafe environment in which psychological symptomatology such as suicidal ideation, disassociation, depression, restricted ranges of effect and anxiety are appearing.¹⁹⁵

A child detained at Curtin told the Inquiry of the stress caused by witnessing self-harm:

My world has become like upside down, because I have never seen things like this, I see people who bury themselves alive one day. I wake up in the morning, I see people have buried themselves, I see people go on the tree and just jump down just like that and I see people who cut themselves, I see officers hit woman and children with batons, or use tear gas. I just, it's too much for me, I don't know why and sometimes I wonder you know, it is very stressful to me.¹⁹⁶

The mother of a young child detained in Woomera described how watching others self-harm became an integral part of her child's life:

He doesn't know the life, he has not seen the beauty of the life, [he has] only seen another fence. So when there is a noise outside and he keeps saying, 'Mummy, let's go outside and see who has slashed himself, let's go and see who has hanged himself'. And always he thinks that if there is any noise he thinks that someone has killed himself and sometimes, you know, when he use bad language, I tell him, 'no, don't use this word' and then he says that 'I'm going to get razor and slash myself'.¹⁹⁷



Children in playground at Woomera with hunger strike in background, January 2002.

Doctors suggest that the prevalence of self-harm in immigration detention centres encouraged children to engage in self-harm themselves:

... children are very susceptible to the influence of adult behaviour around them and in a very confined community such as immigration detention, children are witnessing and are unable to be protected it seems from witnessing the despairing and often self-mutilating acts of other adults. When children are unable to be offered an alternative behavioural strategy or modelling for dealing with despairing feelings, hopelessness, anger, then often they will model on the kind of adult behaviour they see in a copycat kind of way.¹⁹⁸

Detainees confirmed the 'copycat' theory. The mother of a young girl detained at Woomera told the Inquiry that:

... and when they see the self mutilation from everybody, all the time they talk about this and sometimes they do this, like, my daughter tells me if you are angry, if you are not rest, you can cut yourself with razors and sometimes, all the time they talk about drinking shampoo, drinking detergent or hanging.¹⁹⁹

The mother of a teenage boy at Woomera suggested that witnessing self-harm had a similar suggestive impact on her son:

[My son is] seeing all things happening around and people committing suicide and sewing their lips together and not eating and the blood and all this violent acts. It doesn't help him at all and he feels frightened. In fact he said he would like to kill himself by taking some shampoo and I have to try to convince him to be patient.²⁰⁰

This perception was further reinforced by the father of children detained at Curtin:

Unfortunately the environment is not very healthy because every day they are witnessing people who are going on top of the tree, who are suiciding or just cutting their body by blade or jumping, shouting, doing everything violent and they are witnessing and they think this is a game they have to participate in it. It's a very dangerous situation and we cannot have any control of it.²⁰¹

The Inquiry met a young boy at Curtin who explained his reason for 'cutting' himself:

I saw so many of those incidents which [is why] I got this urge to do it. I wanted to see what sort of pain is that or rather I wanted to experience the pain to see what sort of pain is that.²⁰²

Some children who had not yet self-harmed told the Inquiry that witnessing others self-harm made them fear for their own safety:

It's very hard for me to see that people have to come to that level that just for the sake of a visa, hurt themselves, or they're willing to climb the tree and hang themselves, I suffer, it is very painful for me. Sometimes I wonder that I might do one day this, I wonder about this. But I try not to because of the sake of my family.²⁰³

A last resort?

(b) Prevalence of self-harm by children

The Department and ACM provided the Inquiry with extensive documentary evidence of children's self-harm.

DHS told the Inquiry that the majority of the 137 notifications received between January and July 2002 regarding children detained at Woomera related to actual or attempted self-harm:

The majority of numbers have been around the self-harming behaviour which again either comes under physical abuse if the way in which the notification is received alleges that an adult person has inflicted the harm on the child during the activities such as the lip stitching times or the hunger strikes. Then under the neglect, it would be around parents not taking protective action, or it is alleged that parents are not taking protective action, in relation to young people and their suicide attempts or their own self-harming, slashing of skin and drinking shampoo and other self-harming activity. So they would be the majority of our notifications.²⁰⁴

A FAYS assessment report describes how versed children were in the various options for self-harming behaviour. This report concerns an investigation into a suicide pact made by 11 Afghan unaccompanied children:

When asked how they expressed they would do this the lawyer indicated they mentioned:

- throwing themselves into razor wire
- drinking shampoo or other products they could obtain (detergents/disinfectants)
- slicing skin with razor blades
- hanging themselves
- banging rocks into their skulls.²⁰⁵

An example of the various means by which children actually self-harmed is demonstrated in the protest at Woomera in January 2002 as set out below. Further discussion of these instances of self-harm can be found in Chapter 14 on Unaccompanied Children and Chapter 8 on Safety.

Snapshot of self-harm, Children at Woomera, 13 January to 29 January 2002

A very high level of self-harm was noted during an Inquiry visit to Woomera at the time of mass hunger strikes in January 2002. Commission officers saw evidence of self-harm on the bodies of children and young people in the compounds and on those interviewed. Children also spoke frequently about harming themselves and parents expressed distress about their children's threats of self-harm.

Actual self-harm

Lip-sewing	7 children (two children sewed their lips twice)
Slashing of body	3 children (14-year-old boy who sewed his lips twice also slashed 'Freedom' into his forearm)

Ingestion of shampoo	2 children
Attempted hanging	1 child
Unspecified self-harm	2 children
Threats of self-harm	13 children ²⁰⁶

Another illustration of the types and prevalence of self-harm amongst detainee children is provided in the following snapshot of children at Woomera in June 2002. The comments on each child are from two emails sent from the Acting District Manager of Port Augusta FAYS to the Department's Central Office in Canberra on 14 June 2002.²⁰⁷

Snapshot of self-harm, Children at Woomera, 14 June 2002

1-year-old girl: 'Parents on hunger strike 22/5, [baby] being fed by a 10-year-old cousin, child asked for help to feed [her]. Father stated God would look after the child or the child may have to go without. Mother tired. Father suicidal. Tier 1'.²⁰⁸ 19/5 FAYS recommended 'that an urgent referral be made for Psychiatric Assessment of both mother and father, in terms of the capacity of either of them to provide safe and nurturing parenting'. Length of detention: 14 months.

5-year-old girl and 7-year-old boy: 'mother stated she is going on a hunger strike 28/5, and the children will not be fed. Statement related to whether or not the family are provided with a visa. Tier 2'.²⁰⁹

9-year-old girl: 'admitted to hospital after drinking a bottle of shampoo 29/5. Has witnessed self-harming by adults. Is providing the primary caregiver role for her five younger siblings. Father not interested and mother accepts the self-harm attempts by her daughter, sees her as the spokesperson for the family. Tier 2'. Length of detention: 10 months.

11-year-old boy: 'had superficial cuts to his left forearm 27/5, mother stating he cut himself with a razor. Mother had cut herself on 26/5. Tier 2'. '[He] was in the play area where he tied a sheet around his neck and then held a razor to his throat telling officers not to come nearer or he will slash. He also requested his father be cured by tonight or you will see something the compound has never seen before (father starving himself)'. Length of detention: 14 months.

13-year-old boy: 'attempted to hang himself 17/5, tied a bed sheet around his neck to some playground equipment. Kicked a chair away from himself when officer asked him what was wrong. Tier 2'. Length of detention: 14 months.

Same 13-year-old boy and 11-year-old sister: 'Both are serious suicide risks. Parents depressed and unable to care for them. Tier 2'. Length of detention: 14 months.

14-year-old girl: 'stated she is on hunger strike in protest for not receiving a visa, 29/5. Tier 2'. Length of detention: 10 months.

17-year-old unaccompanied boy: 'disclosed he had been sexually assaulted but would not name perpetrator. Later overdosed on hidden medication'. '[He] thinks of suicide all the time and has tried many times including trying to electrocute and hang himself. Feels hopeless, tired with life. General practice intake'.²¹⁰

A last resort?

A report conducted by DHS in August 2002 noted an increase in the prevalence of self-harm amongst children over the preceding months:

Reports of self-harm, threats of suicide and suicidal ideation amongst the children have been reasonably regular throughout this year but have escalated during recent months. Such reports are generated by the centre itself, after a critical incident, or by CAMHS [Child and Adolescent Mental Health Services] counsellors who have identified significant suicidal risks with specific children. Some children have had one incident of self-harming but there are a number of children where such behaviour has become regular.

Since January 2002 a total of **50 reports of self-harm** have been raised on **22 children**, ranging in age from 7 years to 17 years. These incidents included hanging attempts; self-harm by cutting arms or ingesting shampoo; and persistent depression and/or suicidal thoughts. The most frequent incidents occurred with children who are 10 and 12 years of age. Children aged 14 years are the next highest sub-category represented in this group.

60% of these reports related to children aged 12 years or less.²¹¹

In visits to detention centres in 2002, the Inquiry met several children who were involved in hunger strikes, or who had recently self-harmed. Children told the Inquiry that the hunger strike for them was connected to their length of detention. A girl detained at Woomera reported that:

I have been here for 1½ years, either eating or sleeping and nothing happens. We are not free, and if you eat nothing will happen.²¹²

Case Study 3 at the end of this chapter provides detailed consideration of one child's involvement in self-harm. This case study shows that the child made repeated efforts to hang himself, drink shampoo, throw himself onto the razor wire and slash himself. The child also suffered from sleep disturbances and depression.

9.4.4 Long-term impact of the detention experience on children and the Australian community

The Inquiry received evidence of the potential long-term impact of mental health problems in children in detention after they have been released:

It is likely that current policies and practices around placement of children and young people who are asylum seekers in Detention Centres removes the protective factors necessary to recover from trauma, and to build resilience, and can place them at significant risk of lifelong distress and dysfunction.²¹³

Psychiatrists told the Inquiry that the long-term mental health problems caused by detention are likely to be a significant cost to the Australian community:

These children and adolescents are likely to need, given the severity of the problems that they already have, long term mental health treatment. Ideally you would have a multi-disciplinary approach to managing these children and their families. On average children with post traumatic stress disorder

of this magnitude need treatment for at least 6 to 12 months. Some will need longer, particularly some of the very young children who have developmental problems.

They will also need things like remedial education and preferably group activities to look at improving their peer relationships and socialisation. Their parents will also need support. We're roughly talking about in terms of just the one to one treatment component on average across the disciplines about \$100 an hour. More when we add the extra components that are needed and I think we can do the calculations. It's a very significant health bill that we're looking at that the Australian community will need to fund.²¹⁴

9.4.5 Findings regarding the seriousness of mental health and development problems for children in detention

The Inquiry finds that many children in detention have suffered from a range of mental health problems including anxiety, bed-wetting, nightmares, emotional numbing, hopelessness, disassociation, and suicidal ideation.

There is also evidence of a number of children suffering from developmental delay, depression and PTSD. While ACM has argued that at July 2003 the numbers of children diagnosed with these psychiatric illnesses was low, the weight of evidence received from former ACM medical staff, State child protection agencies, State mental health agencies and studies conducted by independent mental health experts involved with current and former detainee children leads the Inquiry to conclude that from January 2002, at least, the incidence of children suffering mental health problems was significant for long-term detainee children. It may be that the difference between the accounts lies partly in the categorisation or level of formalisation of the diagnoses. However, a proper consideration of a child's right to the highest attainable standard of health requires more than simply an assessment of whether or not a child has a formally diagnosed mental illness.

There has been a high level of self-harm amongst these same children. Children in detention for long periods have been surrounded by others who have attempted to commit suicide and some children have copied that behaviour. The methods used by children to self-harm have included:

- attempted hangings
- cutting and slashing their bodies
- swallowing shampoo or detergents
- lip-sewing
- hunger strikes.

While the primary records regarding children in Woomera and the recent studies conducted by mental health experts suggest that a considerable number of children suffered from significant mental health problems over 2002 in particular, the Inquiry has not sought to determine the precise numbers of children who have suffered from mental health problems. No matter what the statistical prevalence of mental illness, the Inquiry finds that the detention environment has had a negative impact

A last resort?

on the psychological well-being of children. The longer they are in detention the higher the risk of harm.

Problems created or aggravated within detention centres can potentially have a long-term impact on children.

9.5 What measures were taken to prevent and treat mental health and development problems in detention?

As discussed earlier, the Department has the ultimate duty of care with regard to the mental health of children in detention. ACM was responsible for providing a sufficient standard of mental health service to detainees. The Department was responsible for monitoring this service provision and taking action where it is insufficient.

The Inquiry acknowledges that the prevention and treatment of mental health conditions in detention is difficult, because many of the problems are caused by the detention environment itself or other factors that are outside the control of medical staff. This connection highlights the difficulty of protecting the best interests of children within the detention environment. It also emphasises the importance of ensuring that children are detained as a matter of last resort and for the shortest appropriate period.

However, this section examines the measures that have been taken to prevent and treat mental health problems in detention within that context, including the following:

- identification of mental health problems
- treatment of mental health problems of children in detention
- prevention of self-harm by children in detention
- referral to State mental health agencies
- implementation of recommendations regarding the mental health of children.

This section also considers the question of whether mental health conditions amongst children in detention can be treated in the detention environment.

9.5.1 Identification of mental health problems

The Department states that mental health screenings of children are conducted when they are taken into immigration detention, during the initial health screening provided to all detainees.²¹⁵ As noted earlier, ACM policy also required assessment of mental health within the initial health screening of detainees.²¹⁶ However, the Medical Assessment forms used for initial health screening of children, which were provided to the Inquiry by ACM, contained no section for comments regarding a child's mental health. This is in contrast to the form for adults, which had an attachment titled 'Mental Health Questionnaire/Observations'.

The Inquiry obtained complete medical records for 36 children from Curtin, Port Hedland, Woomera and Villawood. A review of these records indicates that while

initial health screenings were conducted for at least 26 of these children, specific mental health assessments were only carried out for two children. Both of these were unaccompanied children detained at Curtin, for whom the adult form, including the attachment regarding mental health, was completed.²¹⁷

A mental health practitioner formerly employed at Woomera confirmed that generally the initial health screenings of children did not include a mental health component:

We were unable to do any [mental health] screening or routine checks. The only screening I did was of unaccompanied minors in my first visit. I would have liked to have screened all children on their arrival but could not. Children had medical screening and sometimes things would be picked up and referred to us by caseworkers and teachers and DIMIA, but this did not happen often.²¹⁸

It therefore appears that assessments of children's mental health were not routinely conducted when the children arrived in detention, as required by the IDS and ACM policy and reported to have occurred by both the Department and ACM. Furthermore, there is no evidence of the Department monitoring compliance with these requirements.

The absence of initial assessments makes it difficult to determine whether the treatment of a child's mental health problems was appropriate to the child's needs from the moment of arrival in detention. It also weakens the Department's submission that the mental health problems of children can be solely attributed to pre-existing problems, as there appears to have been no systematic recording of what those pre-existing problems were.

9.5.2 Treatment of the mental health problems of children in detention

The Inquiry received evidence that mental health staff working in detention made considerable efforts to respond to immediate mental health problems amongst detainees. However, there is also evidence indicating that at certain points in time there were insufficient mental health practitioners to deal with the problems that arose. The Inquiry has also heard that there were inadequate processes in referring children with mental health problems to specialist services. Furthermore, the Inquiry has seen no evidence of torture and trauma services for detainees.

(a) Numbers of mental health staff

An adequate number of staff is critical to the provision of an appropriate standard of mental health care.

The Department informed the Inquiry that 'since the significant influx of unauthorised boat arrivals there have been instances where the detention services provider found it challenging to fill some mental health services vacancies'.²¹⁹ However, most of the evidence concerning insufficient mental health staff is from 2002, at which time there was a significant decrease in the overall number of people in immigration detention, including children, but an increase in the number of children who had been in detention for very long periods of time. For example, the number of children

A last resort?

in detention on 1 July 2001 was 631, compared to 138 on 1 July 2002; however, the number of children who had been detained more than year in July 2001 was 32 compared to 92 in July 2002.²²⁰

Some of the evidence regarding insufficient staff numbers comes from the Department's own records indicating that it was monitoring the provision of mental health services. For example, the Department Manager from Curtin was concerned about the number of mental health staff in the centre in April 2002:

During April there [were] 1.5 psych nurses and one counsellor on site. Concerns were raised with ACM as to the insufficiency of these numbers given the pre and post riot atmosphere and the increasingly long term population.²²¹

In April 2002, the Port Hedland Department Manager's report stated '[o]ngoing reductions in numbers of ACM staff, particularly in the mental health area, [are] an increasing problem'.²²² In May 2002 the Port Hedland Department Manager's report noted:

Absence of the Counsellor and, for most of the month, the psychologist, at a time of increased need for mental health services.²²³

In the Contract Operations Group meeting of 23 May 2002, the Department raised concerns about a general 'decrease in the level of service provision in the centres, particularly in relation to psychologists and counsellors'.²²⁴

The Inquiry received further evidence of insufficient numbers of mental health staff in detention from DHS, a doctor and a psychologist who had worked in detention centres and a consultant psychiatrist.

DHS reported in August 2002 that '[t]he provision of psychological and psychiatric services to children and adolescents is grossly inadequate for their short and long-term needs'.²²⁵ DHS went on:

The provision of medical services does not have sufficient scope to provide for the acute and long term psychological and psychiatric needs of the detainees. This particularly applies to the needs of children and adolescents. Behaviours of self-harm are minimised; depression in very young children is rarely recognised. The local town doctor provides the primary medical service and this is an incredible drain upon one person.

The health service cannot provide sufficient monitoring of children and adolescents at risk of harm to prevent multiple episodes of slashing of arms, ingestion of tablets or shampoo and attempted hangings. This deficiency is as much a resource issue as a management issue.²²⁶

DHS also reported that there was inadequate access to child psychiatrists at Woomera given the high needs of the children there:

The lack of immediate access to direct psychiatric diagnosis and care is considered to be a major gap in the centre's health service. Similarly, the lack of a Child Psychiatrist is a prime concern, given the number of depressed and self-harming children present in the centre.²²⁷

A doctor who worked at Woomera in both August 2001 and January 2002 told the Inquiry that the low number of mental health staff meant children and parents could not be properly treated:

Both times I was working there; there were three psychologists, which was not felt adequate for the 900 detainees that were there in January. So the parents could not be supported. Likewise these psychologists could not support the children as they needed. There was no way of improving the environment at that time in terms of providing resources, providing recreational facilities where children can simply play, or draw.²²⁸

A psychologist who worked at Woomera from May to December 2001 reported that the demands of the adult population meant that during that time they generally had to leave the mental health care of children to 'the teachers, social worker and counsellor'.²²⁹

In a report regarding a young mother at Villawood in May 2002, a psychiatrist is noted as stating that:

... the clinical services available at Villawood Detention Centre are inadequate. She advised no specialist medical health arrangements are in place at the Centre. She advised that there were lots of people with untreated post traumatic stress disorders who are isolated and unsupported, presenting a very difficult and dangerous situation. [The doctor] advised there is no support for young parents in the detention centre and most of the children there are psychologically disturbed.²³⁰

The Department and ACM both stressed that children in detention received mental health services comparable to those provided to children living in the Australian community.²³¹ While this may have been the case at certain points in time, the evidence suggests that the provision of mental health staff was often inadequate and that they struggled to meet the heightened needs of children in detention.

In any event, it is important to remember that since children and their parents are deprived of their liberty they, unlike children living in the Australian community, have no opportunity to independently seek the medical services that they believe best cater to their needs. This places a higher burden on the Department to ensure that children are offered the health services that match their needs – and in the case of children in detention those needs may be greater than many children in the Australian community.

In addition, the evidence suggests that the detention environment itself is a major contributing factor and treatment within the detention centre is unlikely to be of great effect. This is discussed in section 9.5.4 below.

(b) Turnover of mental health staff

Another issue affecting the quality of mental health care in immigration detention centres was the high rate of staff turnover, reported by the Port Hedland Department Manager in March 2002 and the Woomera Department Manager in April 2002. The Port Hedland Manager said that the movement of specialist staff between centres

A last resort?

'is impacting adversely on the implementation and continuity of management plans for at risk individuals'.²³² The Woomera Department Manager states that 'I continue to have some concerns about the selection and temporary employment of some psychologists. There is little continuity in case work possible as most come for only a six week contract'.²³³

DHS also stated that the high turnover of staff in centres made it inappropriate for the staff to be involved in more detailed work with families:

as far as ongoing case management services, continuity, they have 6-week contracts and they are in and out and if you are actually talking about mental health issues, research and experience would tell you that there needs to be some consistency, there needs to be some continuity before those things can be addressed.²³⁴

A mother detained at Curtin said that 'the problem is every time they use a different person, a new person and as soon as I start to trust someone and talk about my problems, the next time there is a new person'.²³⁵

ACM informed the Inquiry that although there was significant staff turnover, continuity of care was achieved through the rigorous documentation of care, a team approach, clear case management and care plans and regular review.²³⁶ ACM also told the Inquiry that it was difficult to predict the 'most useful staffing mix, given that the length of time that people would be held in detention was unable to be determined', but that as 'the need for provision of more intense mental health services [became] clearer, ACM responded appropriately by recruiting more staff'.²³⁷

(c) Referral to specialist mental health services

Referral to State mental health services is extremely important for children in detention suffering from mental health problems. As noted earlier, ACM policy requires the referral of detainees with suspected psychiatric illness to specialist mental health services. ACM informed the Inquiry that they have always referred detainees 'to external specialists or to services where the provision to respond on site has been unavailable'.²³⁸

Concerns about the safety of children, including those with a mental illness, generally result in the notification of the State child welfare authority. This is discussed further in Chapter 8 on Safety.

The process for referring children to State mental health services seems to have followed a notification to the State child welfare authority. In an August 2002 report, DHS noted that this process could lead to delays in the treatment of children:

These recommendations [for psychiatric, developmental and family-functioning assessments by CAMHS] are processed by sending the FAYS report to DIMIA in Canberra which then forwards its own recommendations to the Woomera centre. The health service staff (usually the Psychologist) then activates whatever referrals have been approved.

This process results in undue delays in such referrals. Such delays place children (and parents) at increased risk of harm and there have been instances where further serious incidents have occurred before CAMHS was notified about the family.²³⁹

This report concluded that:

The process of approving and enacting referrals to external mental health services is cumbersome and slow. These delays place many children at an unacceptable level of risk in the interim. Once the external agency is involved, accessing counselling and treatment is problematic and affected by resources at the centre.²⁴⁰

The Department states that delay often rests with the State agency, however, the evidence indicates that the several steps involved in the referral process mean that there may have been a delay prior to the State agency receiving the referral.

For example, a child who was interviewed by DHS in March 2002, exhibiting signs of depression, appears to have suffered as a result of this process:

[The child's] threats of self-harm continued at which time FAYS recommended that he be referred to CAMHS for assessment. Before this was enacted, [the child] had moved from threatening to harm himself to actually cutting his wrists and arms. Whilst he did not do much physical harm to himself, this behaviour was very significant because the child's own father had made a number of attempts to hang and cut himself.

It was some weeks before CAMHS received the referral information following FAYS recommendations about this child.²⁴¹

The mental health of this child and his family are further discussed in Case Study 1 at the end of this chapter.

The Inquiry also heard that there are some practical and logistical issues compromising the provision of service from State agencies. CAMHS identified the following issues of concern:

...

2. Practical difficulties in providing follow up, arranging appointments are regularly met by CAMHS staff in attempts to coordinate with ACM to see these families. These include lack of availability of transport for families to appointments in Pt Augusta and Whyalla or difficulties arranging for CAMHS staff to have access to families in Woomera, either at the IRPC or Woomera hospital.

3. Access to families is particularly reduced during periods of high stress or 'red or amber' alert in the IRPC, times when the children and families are most vulnerable and when children become involved inevitably in hunger strikes, violence and conflict between adults and staff in the centre.

4. Referrals occur on an ad hoc basis and as mentioned earlier, families may be referred and soon after withdrawn from referral by another member of ACM staff. No new referrals have been received in the last 4 weeks although

A last resort?

negotiations have continued about access to assess those children previously referred and then withdrawn.²⁴²

ACM informed the Inquiry that there has been a practice of referring detainees to external specialist services since ACM was appointed as the service provider.²⁴³ In relation to Woomera, CAMHS gave evidence that:

The first referral of a child or family from Woomera IRPC to CAMHS occurred in January 2002. No further referrals occurred until May 2002. Since then a further 9 families have been referred and assessed.²⁴⁴

The fact that the first referral to CAMHS occurred in January 2002 is probably a consequence of the most severe cases of mental illness amongst children detained at Woomera developing at that time amongst long-term detainee children.

Finally, there is no evidence that specialist torture and trauma services were offered to children in detention. In the case of NSW, the specialist agency, Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), explained why they did not provide services within detention centres:

Before the end of 1998, STARTTS had some direct contact with people while they were in detention. We were sometimes asked to provide assessments of people in the Villawood Detention Centre, usually people in extreme distress or being held in the high security section. We also provided counselling to some detainees who came to our office accompanied by officers of the Australian Protective Service.

When a private company, Australasian Correctional Management (ACM), was contracted by the Commonwealth to run the detention system in November 1997, this arrangement ceased. The ACM refused to provide the escort service to our office, stating it was not part of their contract, and we refuse to provide counselling services in the counter-therapeutic environment of the detention centre for sound professional reasons ...²⁴⁵

It is surprising to the Inquiry that the services of specialist torture and trauma services were not employed to a greater extent, given that the Department and ACM both accept that it is likely that children in detention will have experienced significant trauma prior to their arrival in Australia.

9.5.3 Prevention of self-harm of children in detention

The Department states that both it and the services provider take the protection of children from self-harm very seriously. As noted earlier, ACM has informed the Inquiry of their view that they have 'no capacity to remove the stressors (visa processing) underlying the self-harming behaviour'.²⁴⁶

ACM stressed to the Inquiry that group self-harm:

is a protest against external factors which in this case, are immigration policy and processing. This is not suggesting that detainees are not experiencing some form of psychological distress, but rather that the source of the distress is issue (immigration) specific.²⁴⁷

ACM further states that:

ACM is limited in the ability to ‘treat’ and prevent the behaviour. Irrespective of the amount of psychological or psychiatric intervention provided by ACM, the stressor in these cases cannot be removed or alleviated by this intervention or any other intervention or action taken by ACM.²⁴⁸

Furthermore, ACM reported that ‘the prime objective of ACM in these circumstances was to prevent any death or serious injury resulting from protest behaviour’.²⁴⁹

The Department identified the following strategies to respond to self-harm by children:

Strategies to prevent and manage self harm include:

- providing onsite clinical services;
- developing individual case management plans;
- expanding and/or modifying services and programs;
- placing identified ‘at risk’ children on HRAT [High Risk Assessment Team] monitoring;
- implementing Centre Emergency Response Team (CERT) processes; and
- holding weekly teleconferences between all DIMIA Managers and Central Office staff ...

If a child has self-harmed, the Services Provider conducts an intensive clinical and operational assessment of the incident to identify causal factors and prevention strategies that might be employed. The child is referred to appropriate health professionals and counselling staff, and may also be referred to child psychiatric services if this is clinically indicated.²⁵⁰

The Department further noted that strategies used by ACM to prevent self-harm include:

removing opportunities for self-harm; ensuring that detainees and parents in particular understand that there is no link between self-harm and the grant of a visa ... ; [and] preventing where possible children witnessing self-harm incidents and instances where children might learn about self-harming behaviours ... ²⁵¹

Although these strategies appear appropriate in principle, in practice they were not always effective to prevent further self-harm. For example:

- onsite clinical services were often inadequate and unable to meet the needs of children
- case management plans for all children in detention were only introduced at the end of 2001²⁵²
- teleconferences, while they do indicate discussion of individual children, do not indicate the development of extensive strategies to meet their needs.

While the systems may not always have been effective in preventing self-harm, they have been successful in preventing the death of any child by self-harm. Given

A last resort?

the high risk factors, this is to be commended; however, international law requires more than the prevention of death.

Other than parental supervision, the two strategies that provided the closest observation of children 'at risk' are the High Risk Assessment Team and observation rooms, as discussed below.

(a) High Risk Assessment Team (HRAT)

The Inquiry received extensive High Risk Assessment Team (HRAT) records, which indicate that close watch was kept on children who were suspected to be at risk. ACM suggested that the fact that there have been no suicides by detainees who were on HRAT demonstrates that it is effective in preventing self-harm.²⁵³ The Department described the HRAT process as having the following functions:

Detainees who have self-harmed are required to be treated for their injuries immediately. After treatment, the detainee is subsequently referred to the High Risk Assessment Team for ongoing monitoring and follow-up. Complex cases, particularly those involving repeated self-harm incidents are managed intensively within the High Risk Assessment Team system and may also be reviewed by the detention service provider's head office health service managers.²⁵⁴

The Inquiry agrees with the Department's statement that the HRAT records show that:

a number of children who had threatened self-harm, or showed strong indicators that they were likely to self-harm, did not self-harm while under observation.

However, there are some instances, where the HRAT watch was not able to prevent further self-harm. See Case Study 3 at the end of this chapter which describes a child who continued to self-harm whilst on HRAT observations.

The HRAT process was focussed on surveillance as a technique of preventing self-harm. It involved detention officers rather than mental health professionals and did not extend to therapeutic care.

(b) Observation rooms

Where the risks of self-harm are particularly high children have been placed in solitary observation rooms to allow closer watch.

The Inquiry heard of an unaccompanied Iraqi boy at Port Hedland who was placed alone in a padded room after threatening to cut himself with a piece of broken glass. The ACM psychologist there, who referred to the room as the 'Romper Room', reported:

Brought up to Medical after CERT called; [the boy] had piece of broken glass to throat and had superficial cuts to wrists. Presentation was unsettled, demanding and tantrum-like. Eye contact good, body posture restless, and voice raised. Reported that he engaged in self-harm and erratic behaviour

in order to get attention, and in particular in the hope of getting moved into the family block. Situation was explained regarding the consequences of his dangerous and impulsive behaviour, and how his subsequent beh[aviour] would determine his level of obs [2 minute, 15 minute, 30 minute, etc] and how quickly he would return to the compound. Was demanding and unaccepting (unreasonable) of this, and was consequently forcibly taken to the padded room and placed in suicide proof gown, as required by this present level of agitation and risk level. Placed on 15 min obs[ervations]. To be reviewed regularly by [Mental Health Team]. Visits encouraged after 18 hours, and will be used to encourage [the boy] to develop more settled and adaptive behaviour. Still surprisingly immature given age and background.²⁵⁵

After a review by the mental health nurse three days later, the boy was still in the 'suicide proof gown'. The nurse noted:

Explained to him again why he is in K Block and padded room, and that he needed to display positive non self threatening behaviour. He began to say he may as well be dead, but changed his demeanour once he realised that nothing would change the set procedure and that he would not be immediately returned to the compound. Explained to him first step is his own clothes, and normal room. If behaviour continues to stabilise then view to letting him return to compound. Discussed with Op[eration]s Manager – he will be given normal clothes and be moved into another room. Will review him again tomorrow.²⁵⁶

The medical reports on this child indicate that he spent eight days in the observation room (three days in the padded room and another five days in another observation room that 'was less austere').²⁵⁷

ACM states that the management of this case is 'consistent with the best practice of managing people in custody who are at high risk of suicide' and goes on to describe that:

- In an institutional environment the main objective when people present with such high risk behaviours is to keep them alive. It is the ultimate duty of care of the service provider.
- The treatment of the underlying motivator cannot be dealt with while such high risk behaviour is being demonstrated. The presenting behaviour must be managed to keep them alive as the first priority.
- In a secure setting this can only be achieved by removing all possible avenues and opportunities to kill themselves and provide the maximum opportunity to observe the person. This requires placement in the most sterile place possible to remove access to all kinds of objects of potential harm.
- In this case the detainee was threatening to cut his throat. He was not put in the room for punishment. He was put in the room as that was the only option to prevent him killing himself. This decision was made by clinically qualified professionals.
- The strategy worked and he remained alive, he did not commit further injury to himself and he was returned to the general detention centre community within eight days.²⁵⁸

A last resort?

ACM's detailed response raises three important points. First, it is clear that having children in the 'institutional environment' of a detention centre limits the options available to treat children who are psychologically unwell. Second, the Inquiry is concerned that the fact that the boy stayed eight days in the observation room suggests that he may have been better off in a psychiatric hospital than in the 'institutional setting' of a detention centre. Third, the general nature of ACM's response suggests that the policies regarding the use of observation rooms did not include any special considerations regarding the possible impact of these strategies on children as opposed to adults.

The Department states that children are only taken to an observation unit if family members are 'involved in the decision making process'. It gives an example of an incident where a child was placed in an observation room in the medical centre. According to the incident report, the child's parents were 'notified of the child's placement in medical and did not raise any issues with this placement'.²⁵⁹

ACM also states that:

In the very few instances where a child has been placed under continuous medical observation, it has occurred with the full permission of the child's parents who usually remain with the child during their brief stay.²⁶⁰

However, the Inquiry is concerned that there are no specific guidelines requiring consent for such separations, and this may lead to children being isolated from parents against their will. There is evidence that on one occasion the Centre Manager gave permission for a boy to be placed in an observation room overnight without parental consent, even though he was accompanied by his parents.²⁶¹ While this may be an isolated incident, it indicates that, in the absence of clear procedures, there is a risk that ACM may make decisions to place children in observation without parental consent, resulting in involuntary separation from their parents.

(c) Parental care

The Department has suggested that it is the parents' responsibility to protect children from self-harm. It also suggests that there is a belief amongst detainees that self-harm might affect visa outcomes and implies that if parents are of this belief it may encourage their children to self-harm:

Some detainees have expressed a view that self harming behaviour will positively influence the outcome of their application to stay in Australia. The Department continues to stress to all people, and parents in particular, that there is no link between self-harm and the grant of a visa and that to encourage this belief could place children at further risk of harm.²⁶²

The issue of parental responsibility is discussed further in section 8.3.4(b) in Chapter 8 on Safety.

9.5.4 Can mental health problems be treated in detention?

The Inquiry consistently heard from mental health experts that children and their families who are psychiatrically unwell cannot be treated within the detention environment because the environment is one of the major causes of the problems.

ACM has stated that:

Unfortunately, as need increases the impact of the mental health services become less effective. The issues producing the mental health problems cannot be removed.²⁶³

A psychologist who worked at Woomera told the Inquiry:

I was working in a no win environment because I couldn't change the environment. No matter how much I worked with the clients, I couldn't change the cause of the behaviour, the cause of their stress, it's like having a patient coming into the hospital with a nail through the hand and you are giving them Pethidine injections for pain but you don't remove the nail. That's exactly what is happening in Woomera. You've got people down there with nails through their hands, we're holding them, we're not treating the cause. So, the trauma, the torture, the infection is growing. We are not treating it, we're just containing it. Eventually when those people return to their homelands, if they don't get temporary visas, they are going to carry that with them.²⁶⁴

The Inquiry has received numerous psychiatric reports that stated that the only way to treat the mental illness of children in detention is to release them with their family.

For example, a psychiatric report regarding siblings aged 13 and 11 stated that neither child could be treated in the detention environment. Regarding the brother (see further Case Study 3), the report stated:

[His] psychological condition cannot be properly cared for within the detention environment. There is no psychiatric intervention that can be carried out within the current environment that is at all likely to be helpful to him. In particular, antidepressant medication offers no significant likelihood of enhancing his wellbeing while he and his family remain in the detention environment.²⁶⁵

Of the sister it stated:

[She] is significantly impaired and her psychological condition cannot be properly treated within the detention environment which itself is a major contributing factor. There is no medication, or other intervention, that offers significant likelihood of enhancing her wellbeing while she remains in the detention environment. Removal from the detention environment with other members of the family would confer significant benefit.²⁶⁶

A last resort?

The report recommended that there was 'an urgent need for the children to be removed from the detention environment. The strong preference would be for them to be with at least one of their primary caregivers'. The report also stated that there:

is no place for mental health intervention with these children whilst they remain in the centre, the detention experience being the primary contributing factor to their current depression and suicidality...

In conclusion, any course of action other than their immediate removal from detention must be considered a serious disregard for the emotional wellbeing and physical safety of these children.²⁶⁷

These recommendations were not implemented. As at December 2003, these children were still in detention.

In November 2002, an ACM psychologist outlined the extent of psychiatric problems at Woomera in a letter to FAYS concerning seven children. She reported that six of these children demonstrated symptoms of either depression or PTSD. The letter concluded that:

These children cannot be treated in the detention environment. Helping the children is inseparable from the safety and well being of the parents who equally require appropriate mental health interactions and appropriate psychiatric care. These children continue to suffer severe mental health problems. This is a medical and psychiatric emergency.²⁶⁸

The DHS Mental Health Unit has also concluded that:

The over-arching issues raised by these cases and reports are:

- Increasing clinician concern that their recommendations are not being implemented by DIMIA.
- The ineffectiveness of community based treatment delivered at Woomera.
- No effective treatment programs can be put around people while they are in such a noxious environment...²⁶⁹

Thus the connection between continuing detention and continuing mental health problems, in the view of these experts, is close to inseparable.

Case Studies 1 and 2 at the end of this chapter provide further examples of the connection between detention and the declining mental health of families in Woomera.

9.5.5 Implementation of recommendations regarding the mental health of children

Recommendations for actions protecting the mental health of children may be made by ACM mental health staff, State child welfare agencies, State mental health services or independent mental health experts. In some cases these experts have suggested that children be removed from the detention environment.

While the Department relies on these authorities and experts for advice regarding children in detention, it is quite clear that the final decision regarding the implementation of these recommendations rests with the Department itself and not the mental health experts or the State child welfare authorities.

Broadly speaking, there are two categories of recommendations made by experts in relation to the mental health of children. The first category includes recommendations of measures that can be taken within the detention environment, including specific recommendations regarding the safety of children (for example, the movement of a family between compounds due to fears for a child's safety) and general recommendations about the detention environment (for example, increased access to education and recreation programs). The second category includes recommendations for the removal of children from the detention environment, usually due to the view that it is impossible to treat children effectively while they remain in detention.

The evidence before the Inquiry suggests that the recommendations regarding specific and immediate problems or threats within the detention context were often followed.²⁷⁰ This issue is discussed further in Chapter 8 on Safety. However, DHS stated that their general recommendations seeking to improve the detention environment as a whole were not followed as frequently:

The lower rates [of implementation of recommendations] are the ones that are broader than immediate safety. Immediate safety recommendations are implemented on most occasions. It is the broader recommendations which include external people with expertise such as STTARS [Survivors of Torture and Trauma Assistance and Rehabilitation Service] being involved to provide counselling, the broader assessments and mental health involvement of external agencies, programming around recreation activities, vocational education, employment and training within the centre...²⁷¹

Whether the Department acts on recommendations in the second category, for release from detention on mental health grounds, has depended entirely upon whether a child is unaccompanied, or detained with parents or other family members. Since January 2002, just under 20 unaccompanied children have been placed in the community in home-based places of alternative detention on the basis of mental health recommendations from State health authorities.²⁷²

However, recommendations to release or transfer children accompanied by their parents on mental health grounds were almost never acted upon. As explored in Chapter 6 on Australia's Detention Policy, the *Migration Act 1958* (Cth) and the Migration Regulations severely limit the circumstances in which children or their parents may be released from detention. Restrictive bridging visa regulations mean that whole families are rarely eligible. However, the Department has complete discretion regarding the transfer of families to alternative places of detention. Any residence may be approved by the Minister as an alternative place of detention. For example, the unaccompanied children released into alternative detention are living in foster care in homes that have been approved as an alternative place of detention. As discussed in Chapter 6 on Australia's Detention Policy, the Inquiry is

A last resort?

of the view that the Department has not fully utilised this option for children with mental health problems.

On one occasion it appears that the Department became frustrated with the 'advocacy' role that some mental health specialists were taking. In response to receiving a copy of a July 2002 psychiatrist report recommending the immediate release from detention of the family that is considered in Case Study 2, the Department Deputy Manager made the following comments in an email to the Department's Central Office:

More importantly, this is a copy of a report made by CAMHS after a visit at the request of ACM Health. It seems clear to all here that CAMHS/the Women's and Children's Hospital have been asked to make an assessment, as specialists, to assist ACM Health with their diagnosis and treatment of the family, and for them to provide advice to DIMIA based on that assessment.

They have not been asked to carry out assessments in relation to visa options. Nonetheless they have forwarded a copy of their report, to this office, stating that the family cannot be treated in the detention environment. ...

While it is good for us to get this info – it seems that the Women's & Children's Hospital are in fact moving outside of what they have been asked to do/they are not following what ACM Health & [the Woomera GP] consider to be proper professional channels, and as a result appear to have their own agenda in relation to the IRPC.

This is an ongoing issue in any case, and is only passed on to you so that you have a sense of how some State Health services here seem to be advocating rather than treating/diagnosing.²⁷³

These comments indicate a reluctance to properly consider the recommendations of consultant psychiatrists to which detainees have been referred because the recommendations are for release from detention rather than for treatment within detention.

On the other hand, staff from State authorities felt frustrated that they could not implement recommendations that they believed were important for the mental health of children. State authorities have indicated to the Inquiry that the content of their recommendations were often shaped in light of the known limitations of the detention regime. In particular, staff felt constrained from making recommendations that children be removed. An independent report by Robyn Layton QC regarding the position of DHS under its Memorandum of Understanding with the Department stated that DHS is:

... placed in a situation of compromise in relation to the welfare of children if the Federal Minister as a matter of policy is not prepared to release the whole family into the community (which appears to be the case in practice up to date). In that case [DHS] is trying to weigh up and make recommendations on potential options all of which are likely to be detrimental to the best interests of the child, such as:

- that the child remain with his family in the detention centre, or

- that the child be taken away from both of his parents or other family in the detention centre and placed in alternative care; or
- that [DHS] try and negotiate a compromise such as release with the child's mother into community detention leaving the father in the detention centre.²⁷⁴

CAMHS summarised the frustrations faced by mental health agencies in making recommendations regarding the mental health of children in detention as follows:

In summary, assessment and in some cases follow up services are currently being provided to 9 families (14 children) in Woomera IRPC. Despite some attempts at intervention in the detention context little has improved, and some of the children show deterioration in their functioning. There is currently a very significant escalation in acting out and self harming behaviour by several of the younger adolescent children (11 – 14 year olds). They all remain at high risk of both immediate harm as well as the long term developmental consequences of ongoing time in detention. Recommendations and expert clinical advice has been provided but to date substantially ignored. Similarly it appears FAYS staff are limited in their ability to respond effectively to the child protection needs of children in this traumatising context, where there are not specific allegations against an individual(s). DIMIA ultimately has discretion about acting on recommendations from either Health or FAYS reports.²⁷⁵

However, over 2002, State agencies recommended the release of children from detention more regularly.

This may be due in part to the increasing seriousness of the mental health problems faced by long-term detainee children. The case studies at the end of this chapter give a full chronology of several children suffering from serious mental health issues and the repeated recommendations that were made for their removal from detention, by State authorities, ACM staff and consultant psychiatrists. The case studies show that these health professionals are all of the view that removal of these children with their families from the detention environment is the only effective way to treat their serious mental health problems.

Recommendations for the release of the family in Case Study 1 had not been followed as at the end of 2003. The children from the second family were released on a temporary protection visa after 32 months of detention. Recommendations for the release of the child in the third case study had also not been followed by the end of 2003, although he was placed in the Woomera RHP in January 2003 after 20 months of detention.

The Department informed the Inquiry that:

While the department acknowledges that not all recommendations to release children with mental health issues into the community have been followed, usually because they could not be implemented lawfully, the department advises that it has released several children from immigration detention facilities on mental health grounds.²⁷⁶

A last resort?

However, apart from the unaccompanied minors who were released from January 2002, the Inquiry is aware of only two families who left detention centres on mental health grounds over the period of the Inquiry – one was released on bridging visas, the other was transferred to a place of alternative detention in the community.

The Department points to its efforts to establish the Woomera RHP, and the other housing projects that are under development as at September 2003. Since December 2002, 'all women and children likely to remain in detention for a not short period have been offered accommodation in alternative places of detention such as the Woomera RHP in the Woomera community'. The Department suggests that this has given detainee parents 'a very real opportunity to arrange for their children to leave the immigration detention facility, if they believe that this would truly benefit their child'.²⁷⁷

However, as discussed in Chapter 6 on Australia's Detention Policy, the Inquiry is of the view that because this form of alternative detention requires the separation of two-parent families this may not be the best alternative for families where children are suffering from mental illness. This is demonstrated in both Case Study 1 and Case Study 2. Even for one-parent families the housing projects do not offer the liberty that may be necessary for effective treatment.

Therefore, it appears to the Inquiry that there have been insufficient efforts by the Department to comply with the recommendations of mental health experts that children should be removed from the detention environment. This has resulted in children with serious mental health conditions remaining in the environment that is contributing to their problems.

9.5.6 Findings regarding the treatment of mental health problems

The overwhelming evidence from mental health professionals is that since the detention environment itself is one of the major causes of mental illness amongst children, they cannot be effectively treated while they remain in that environment. While the Inquiry acknowledges (although does not accept) the limitations imposed by bridging visa regulations, the Department has always had the option to transfer families out of detention centres into the community. Since January 2002, the Department has exercised this option in the case of approximately 20 unaccompanied children. However, this option has not been vigorously pursued in the case of children accompanied by their parents. The impact of this failure on some families is illustrated in Case Studies 1 and 2 at the end of this chapter.

For those families who remain in detention centres, the Department has an obligation to ensure that the children have access to the health services necessary to achieve the highest attainable standard of health. Evidence from current and former staff and detainees, Departmental and ACM documents, State mental health and child protection agencies and independent health experts, amongst others, suggests that this obligation has not been fulfilled.

Although general health screening occurred when children arrived in detention centres, there is no evidence that this process included screening for mental illness. The absence of routine and early identification of mental health problems is particularly concerning given the likelihood that children in detention might suffer from prior torture and trauma.

The Inquiry acknowledges that many individual staff members tried to provide the best care they could in the circumstances. However, there were insufficient mental health practitioners to deal with the heightened needs of detainees at various detention centres at different periods of time. The high turnover of mental health staff also impacted on the quality of the mental health care.

The process of referral to State mental health and child protection agencies has been slow and cumbersome. There was no prompt access to child psychiatrists. Specialist access to families was limited during some disturbances – the same time the children were at most risk.

No torture and trauma services were provided to children. According to the NSW specialist agency, STARTTS, this was because ACM refused to escort the patients to their office and they refused to treat the children in the ‘counter-therapeutic environment’ of Villawood.

The Inquiry finds that the strategies in place to address self-harm have been successful in preventing the death of any child by suicide. The HRAT observations also appear to have reduced the numbers of children who may have otherwise self-harmed. The Inquiry notes, however, that the strategies were more focussed on immediate prevention than long-term therapeutic care. For example, the HRAT observations were conducted by detention officers rather than mental health professionals. The Inquiry is also concerned there are no clear guidelines specifically addressing the use of observation rooms for children. In particular, there are no guidelines requiring the consent of parents.

9.6 Summary of findings regarding the mental health and development of children in detention

The evidence before the Inquiry regarding the impact of detention on the mental health of children demonstrates a breach of articles 3(1), 3(2), 6(2), 22(1), 24(1), 37(a), 37(c) and 39 of the CRC.

The evidence before the Inquiry clearly demonstrates that Australia’s immigration detention centres can have a serious and detrimental impact on the mental health of children. A variety of factors contribute to mental health problems for children in detention. All of them are either the direct result of, or exacerbated by, long-term detention in Australia’s detention centres. The longer children are in detention the more likely it is that they will suffer mental harm.

A last resort?

Many children in immigration detention arrive in Australia with pre-existing trauma. Upon arrival in a detention centre they face the stresses of living behind razor wire, locked gates and being under the constant supervision of detention officers. While most detention officers treated children well, some used offensive language around children and, until 2002, officers in some centres called children by number.

Negative visa decisions can create a great deal of anxiety in children and their parents, because such decisions create uncertainty as to their future in Australia and because the effect of the decision is that they will remain in detention. However, one of the most serious problems faced by children is the cumulative effect that the detention environment has on the family unit.

Detention inherently circumvents a normal family environment in which parents have control over the day-to-day decisions concerning their child's life. Parents, like their children, may arrive with vulnerabilities associated with experiences of trauma. The impact of the detention environment on the mental health of some parents carries over to the children who can no longer rely on their support. In some cases, this results in role-reversal with the children taking on a supportive role. In other cases, parents have been hospitalised, taken to medical observation rooms or placed in security compounds. Case Studies 1 and 2 at the end of this chapter demonstrate the serious impact of detention on two families.

All of these factors have caused many children in long-term detention to suffer from anxiety, distress, bed-wetting, suicidal ideation and self-destructive behaviour including attempted and actual self-harm. The methods used by children to self-harm have included attempted hanging, slashing, swallowing shampoo or detergents and lip-sewing. Case Study 3 chronicles the self-harm attempts of one 14-year-old boy in Woomera. Some children have also been diagnosed with specific psychiatric illnesses such as depression and PTSD. The longer children were detained the more likely it was that they displayed one or more of these problems. The impact on children can be long-term.

Mental health experts who examined these children state that the only effective way to address the mental health problems caused or exacerbated by detention is to remove them from that environment. Despite the consistent recommendations from independent mental health experts, ACM staff, State mental health authorities and child protection agencies, the Department almost never removed children accompanied by their parents (as opposed to unaccompanied children) from the detention environment on mental health grounds.²⁷⁸

The combination of laws that result in the mandatory detention of children and the failure of the Department to apply those laws in a manner that results in the prompt transfer of families to the community (either home-based detention or release on a special needs bridging visa – see further Chapter 6 on Australia's Detention Policy) result in a breach of the rights of children to enjoy the highest attainable standard of health (article 24(1)) and constitute a failure to ensure the development of children to the maximum extent possible (article 6(2)). These factors also amount to a failure to take all appropriate measures to promote the recovery and reintegration of children

who have been the victims of trauma in an environment which fosters their health, self-respect and dignity (article 39) and a further failure to take appropriate measures to ensure that children seeking refugee status have received appropriate protection and humanitarian assistance in their enjoyment of the rights in the CRC (article 22(1)).

The Inquiry finds that there was no reasonable justification for the continued detention of children over the clear (and in some cases repeated) recommendations of mental health experts that they be released immediately in the interests of their mental health. The Inquiry finds that the continued detention of children in these circumstances is a breach of their rights not to be subjected to cruel, inhuman or degrading treatment (article 37(a)).²⁷⁹ It also amounts to a failure to treat such children with humanity and respect for the inherent dignity of children (article 37(c)) and a failure to take all appropriate legislative and administrative measures to ensure the protection and care of children necessary for their well-being (article 3(2)). These breaches are the result of both the inflexible nature of the laws under which the children were detained, and a failure by the Commonwealth to use existing mechanisms within the law to ensure removal from a detention centre when children were suffering mental harm.

Given the seriousness of the impact of continuing detention on children, these same failures suggest that the best interests of the child were not a primary consideration in the introduction and maintenance of the laws requiring the mandatory detention of children. Nor was it a primary consideration in the decisions of the Department in the administration of those laws. Accordingly, Australia's mandatory detention laws and the manner of their application by the Minister and the Department result in a breach of article 3(1) of the CRC.

The direct link between the continuing detention of children in Australian detention centres and the increased risk of mental harm makes it unsurprising that the efforts to provide mental health treatment have been relatively unsuccessful. However, the Department must seek to overcome that hurdle by ensuring that children in detention have access to the mental health care services necessary to ensure the highest attainable standard of health in accordance with article 24(1).

The Inquiry acknowledges the considerable efforts of individual staff members to provide the best care possible in the circumstances. However, the Inquiry finds that there was no routine assessment of the mental health problems facing children on arrival. There were insufficient numbers of mental health staff to deal with the problems emerging in children, and there was insufficient access to external mental health experts. No torture and trauma services were available to children who needed that specialist care.

The Inquiry finds that the observation systems in place to prevent self-harm were successful in preventing the death of children by suicide. However, there were no clear guidelines regarding the use of medical observation rooms for children. The Inquiry notes that the suicide prevention systems focussed on immediate prevention of harm rather than holistic therapeutic care.

A last resort?

Therefore, while the Inquiry recognises the difficulties created by the detention environment in ensuring the highest attainable standard of health of children, it finds that the deficiencies in the manner in which the mental health needs of children were addressed amounts to a breach by the Commonwealth of article 24(1) of the CRC.

To the extent that compliance with the JDL Rules is a useful guide to assessing whether or not there has been compliance with article 37(c), it is relevant to note that those rules recommend that there be unobtrusive head counts and this was not the experience of some children in detention. The practice of calling children by number rather than name and the absence of specific guidelines regulating the use of solitary medical observation rooms for children also raises concerns about compliance with article 37(c). However the Inquiry makes no finding on these facts alone, rather it flags these as general considerations to be discussed further in Chapter 17, Major Findings and Recommendations.

In summary, the long-term detention of children in Australia's detention centres has a serious negative impact on a child's ability to enjoy their fundamental rights to recovery from past psychological trauma in a healthy environment, the maximum possible mental and emotional development and the highest attainable standard of health. This highlights the importance of ensuring that the detention of children is a measure of last resort and for the shortest appropriate period of time in accordance with article 37(b).

9.7 Case studies

9.7.1 Case Study 1: Declining mental health of a family in Woomera

This family consists of a father, mother, and a son who was born on 17 July 1990.

20 April 2001

Family arrive at Ashmore Islands. Transferred to Woomera.

August 2001

Mother and son accommodated in the Woomera RHP.

May 2002

FAYS are notified regarding this family after the father attempted to hang himself twice and the son threatened to self-harm. The assessment notes that the son was:

exhibiting clear signs of severe stress: his sleep-talking, nightmares and now sleep-walking indicate deep-seated trauma. The current stressors of detention and his parents' depression are clearly causing [the child] extreme distress ... his mental health will only deteriorate further without sensitive and effective long-term intervention.²⁸⁰

ACM psychiatric nurse notes that the boy's 'mental health and behaviours have deteriorated since his father has been depressed and suicidal. He has attempted to assume the role of head of the household in his father's absence'. The nurse

suggests that the family's problems would be answered by 'a positive response to their bridging visa application'.²⁸¹

Department Manager at Woomera requests an independent medical assessment on whether the family has special needs 'that cannot be cared for [in detention], in order for further consideration to be taken by this Department as to whether they are eligible for bridging visas'.²⁸² The letter notes that 'ACM are indicating that this family may have conditions that cannot be cared for within a detention environment'. The Inquiry did not receive a report of this assessment, or evidence of consideration of a bridging visa application.

At the end of May the mother and son are returned to Woomera from the Woomera RHP.

May 2002 – November 2002

The son self-harms by cutting himself on at least eight occasions. He attempts to hang himself twice.

June 2002

A FAYS report from early June notes:

[The boy] is the only child in a family where both parents are severely depressed and unable to parent him. Consequently, [he] has taken on the role of 'the man of the family' and mother's 'protector'. ... This child has shown serious mood, sleep and behavioural deterioration this year. His self-harm 'gestures' have now escalated to self-harm incidents and he will continue with this behaviour. He is at ongoing risk of self-harm and his parents are unable to support and help him. In fact, he is currently the 'strong one' in the family – and he is only 11 years old.²⁸³

This report recommends that the child and at least one parent are released from detention on a bridging visa.

The Department requests that ACM provide further information about the psychological conditions and treatment of the family 'to assist in [its] assessment of management options for these detainees'.²⁸⁴

ACM psychologist expresses concern that the son is adopting the role of his father by trying to look after the family:

[He] is completely dysfunctional for his age and experiences bouts of depression and uncontrollable rage. Although [he] believes he is fulfilling the correct role in the family, the stresses for a young boy to represent the family under these circumstances is pushing him into extreme and dangerous behaviours.

The report goes on to note that:

The severe family breakdown paralleling the psychological breakdown of the father, plus the growing concerns regarding [the son's] role, needs to be addressed in an environment in which stronger psychological and community interventions can occur. [The boy] in particular, requires input

A last resort?

which is more appropriate to a child his age which is outside of the role which he has acquired at the detention centre.²⁸⁵

July 2002

ACM forwards medical treatment plan to the Department, which makes the following recommendations regarding the family:

Nil improvement likely in current detention setting. Removal of child from negative environment. Alternative housing would assist in family bonding and reduce damage caused by exposure to self destructive behaviour and increase residents ability to cope and care for child.²⁸⁶

A senior psychiatrist and psychologist from the Department of Psychological Medicine, Women's and Children's Hospital, Adelaide notes that the son had not been attending school for the previous two months because he was looking after his parents, and that 'in the absence of ... basic developmental needs, he adopts a parental role as a way of defining himself'. The psychiatrist diagnoses the boy as follows:

[He] presents with a history of depressed mood in association with neurovegetative changes of insomnia, lethargy, anorexia and poor concentration. He describes feelings of hopelessness and helplessness and he is anhedonic. He has made multiple suicide attempts in the past and he is at significant risk of further suicide attempts.

These findings are consistent with an episode of major depressive disorder. There is also evidence of intrusive thoughts, recurrent nightmares, hyper vigilance and consistent of the diagnosis of Post Traumatic Stress Disorder [PTSD], secondary to traumatisation in the Detention Centre.

The psychiatrist recommends that:

[The son] and his family be removed from the Detention Centre as a matter of urgency. [The son's] emotional deprivation and PTSD cannot be treated in the detention context, because that environment is contributing to it. Continued detention increases the risk of self harming behaviour and increased traumatisation ... We do not believe that separating the family at this stage would be in their best interests.²⁸⁷

Another psychiatrist from the mental health service at the Royal Adelaide Hospital wrote to the ACM psychologist at Woomera:

They present as a highly dysfunctional family unit with serious individual psychopathology. I would anticipate that their prognosis is poor and that little can be done to help them whilst they remain in the detention situation.²⁸⁸

August 2002

Child is placed on a Behaviour Management Plan by ACM.²⁸⁹ ACM psychologist reports that the child witnessed his father self-harm, that he was considered a child at risk and suggested that the mother and child be returned to the Woomera RHP. The psychologist notes the psychiatric report of 22 July 2002 that states that the family cannot be successfully treated in the detention environment.²⁹⁰

Head of the Department of Psychological Medicine at the Women's and Children's Hospital, Adelaide assesses family:

I know of no intervention that could be carried out in the detention centre that would benefit [the son] ... An all-of-family approach is urgently required, and this had not proven feasible in the detention centre. I therefore unreservedly concur with [the previous doctors'] recommendation of removal of the whole family from the detention centre.²⁹¹

FAYS assessment report on children in Woomera notes the following regarding this child:

The child ... was interviewed by FAYS in March, 2002 but the lad was, at that stage, refusing to speak to any Psychologist or other medical professional. He was exhibiting significant signs of depression at the time.

[The child's] threats of self-harm continued at which time FAYS recommended that he be referred to CAMHS for assessment. Before this was enacted [he] had moved from threatening to harm himself to actually cutting his wrists and arms. Whilst he did not do much physical harm to himself, this behaviour was very significant because the child's own father had made a number of attempts to cut and hang himself.

It was some weeks before CAMHS received the referral information following FAYS recommendations about this child.²⁹²

Executive Director of the Department of Human Service's Social Justice & Country Division writes to senior officials at the Department's Central Office, enclosing all the experts' reports. She recommends that the family be removed from detention.²⁹³ She also faxes to the Department a report from the DHS mental health unit that suggests that the child is at extreme risk of self-harm.²⁹⁴

October 2002

In early October, FAYS were notified of alleged sexual harassment of the child. The family were offered accommodation in India Compound which they refused.²⁹⁵

FAYS describes the situation as critical and calls a teleconference with the Department, ACM and the GP at Woomera Hospital.²⁹⁶ Meeting minutes state that self-harm incidents had risen so much in frequency that '[the son] now seems to be disassociated when he cuts himself'.²⁹⁷ Furthermore, 'FAYS workers are of the opinion that this family cannot begin to improve as long as they are in any form of detention'.²⁹⁸

Department Manager at Woomera writes to senior officials in Central Office, enclosing all the experts' reports. She notes the following options for the family:

- The consensus appears to be that continued detention at Woomera IRPC will only serve to exacerbate their condition and that transfer to another Centre may assist with our management of the family but would not contribute to any real improvement in the family's health.

A last resort?

- Access to a BVE [Bridging Visa E] may now have ceased following the outcome of the Federal Court appeal. I will need to check whether a FFC [Full Federal Court] appeal is likely, although it should be noted that this would only provide a small opportunity for BVE entitlements.
- Placement in alternative place of detention. Essentially this would need to be a psychiatric facility, or a community placement with extraordinary network of support. [The Woomera GP] cautioned about a placement in the community without very strong and close supervision given [the father's] condition.²⁹⁹

ACM Mental Health staff tell the Department Manager that they are 'gravely concerned' about the family:

It has become progressively difficult over the past several weeks to engage [the son] and his family in any form of communication. Mental Health staff are generally met with verbal abuse from [the son] and at times from his mother and father ... The Mental Health Team continue to attempt on a daily basis to assess [the son] but to no avail ... The ... family are most noticeably becoming more isolative.³⁰⁰

Department's Unaccompanied Minors and Children Teleconference notes that [the son] has self-harmed again, that the Department's Central Office (Detention Operations section) is 'looking into him and his family' and that 'he is also the subject of a FAYS report'.³⁰¹

ACM psychologist writes a Memo to the Department Manager, marked 'Urgent', stating that:

Long term detention has had a devastating effect on [this] family. Not only have [the mother and father] experienced an emotional breakdown, their son's mental state has been significantly affected. [The son] is currently in an extremely fragile emotional state. This is likely to continue to influence many areas of his life including his ability to form relationships, his future risk of psychiatric morbidity and suicide.

Detention of this family at the Woomera Detention Centre is no longer an option. I strongly recommend that the ... family be given alternative accommodation, preferably community based and provided with ongoing psychiatric and psychological treatment and support. Anything less would be a failure in our duty of care.³⁰²

November 2002

The Acting General Manager, ACM writes to the Department regarding this family. The letter states that 'health services staff are doing everything reasonably possible to provide a level of care and management of [the child] and his family however this does not appear to be having any positive impact'. The letter goes on to say:

ACM has also sought external assistance in the management of [this family]. Numerous reports have been written by FAYS and Consultant Health Professionals regarding this family and their ongoing care and management requirements. All external agency reports recommend that the family remain

together and receive ongoing treatment at least in another Detention Centre to Woomera, but preferably in an alternative place of detention.

ACM concludes that:

[h]ealth services staff are of the opinion that the deterioration of this family has reached a level where the options and management strategies available to ACM are insufficient to give a reasonable level of comfort that the risks can be adequately managed.³⁰³

The letter provides to DIMIA 18 items of correspondence or reports on the family.

ACM psychologist reports:

Diagnosis: [Boy] is completely dysfunctional for his age and experiences bouts of depression and uncontrollable rage. He is in the process of developing borderline conduct traits. High risk of suicide.³⁰⁴

January 2003

Family is moved to Baxter detention centre.

On 6 January 2003, CAMHS assessed this family, concluding of the child that:

[He] remains depressed with symptoms of PTSD. He remains at high risk of suicide and the centre is clearly unable to provide the appropriate supports to ensure his safety. I therefore recommend hospitalisation for urgent psychiatric review and intervention.³⁰⁵

February 2003

A psychiatrist from the Women's and Children's Hospital in Adelaide saw the family and reported on 13 February 2003 their significant distress at detention, including the following regarding [the child]:

When I asked if there was anything I could do to help him, he told me that I could bring a razor or knife so that he could cut himself more effectively than with the plastic knives that are available (showing me the many scars on his arm). He said that he could not find anything to distract him, that occasionally he played with the Play Station or watched television.³⁰⁶

This psychiatrist further reported his view that the most therapeutic option is that outlined in documents from 2002, which refer to treatment of the whole family once released from detention. Alternatively, he recommends treatment of the father and son in separate hospitals in Adelaide with the mother staying with the son.

May 2003

This psychiatrist made a further visit to Baxter in May 2003, when he consulted with ACM mental health staff who were unanimous in their agreement that the family cannot be treated in the detention environment. He noted further that:

Each member of this family suffers from severe psychiatric disturbance sufficient to warrant consideration of in-patient admission. We can find no

A last resort?

evidence to change our opinion that [the child] should not be separated from his parents. Thus unless the family are removed from the detention environment they cannot be regarded as being able to benefit from any mental health intervention. As a result the continued position on DIMIA's behalf that part or all of the family needs to remain in detention has the direct effect of denying them any significant mental health intervention.³⁰⁷

September 2003

The Department informed the Inquiry that 'the Department of Human Services in South Australia will develop a comprehensive care plan for the family. The plan will expressly examine options for alternative detention arrangements in the community'.³⁰⁸

December 2003

Family still in detention.

9.7.2 Case Study 2: Declining mental health of a family in Woomera

This family consists of a father, mother and three children. The eldest daughter was born on 1 January 1984, the younger daughter on 1 January 1987 and the son on 1 January 1998.

31 December 2000

Family arrives at Ashmore Islands.

5 January 2001

Transfer to Woomera.

February 2002

Psychiatric report notes that:

- the son was significantly impacted by witnessing riots in December 2001
- the younger daughter was overtly depressed and expressed suicidal ideation
- the eldest daughter had 'masked depression'
- the father was overtly depressed and expressed suicidal ideation

Report recommends that the family should be released from detention, and receive ongoing psychiatric assessment and treatment:

The severity of depression, despair and suicidality in the father and both girls must be considered a psychiatric emergency. The youngest child is also traumatised by ongoing exposure to violence in the centre and affected by his parent's depression. This should not be further prolonged.³⁰⁹

The report recommends that if the family are to remain in detention that they should be moved to a less harsh and isolated centre where they can receive psychiatric

treatment, and that education and recreational opportunities should be provided for the children. Significantly, the report states that:

There is no point in [these] recommendations if the family remain at Woomera IRPC, an environment that is isolating and traumatic for them and where there is inadequate mental health treatment.³¹⁰

May 2002

Letter from the doctor at the Woomera Hospital to the Department Manager recommends that the family be considered for the Woomera RHP:

Each family member is exhibiting some form of mental illness, however the level of illness amongst the two daughters is severe. The parents and two eldest daughters are exhibiting symptoms of major depression and anxiety disorder, and the youngest child is exhibiting behavioural disturbance and bed wetting behaviour.³¹¹

ACM psychologist reports to the Department Manager that the mother and two daughters were 'extremely distressed and presented as being deeply depressed and desperate'. Psychologist assesses that:

... the psychological needs of this family cannot be adequately managed within a detention environment.³¹²

CAMHS assessment is provided to the Department Manager. This report finds that [the two daughters] are at risk of further self-harm and suicide and at significant risk of long-term mental health problems:

[The eldest daughter] exhibits symptoms of depression. Her expression of anxiety, despair and ongoing self-harming behaviour are major concerns. She said that she has attempted to harm herself on more than one occasion.

[The younger daughter] presents herself with the same clinical picture like her sister ... – exhibiting significant symptoms of depression, anxiety, suicidality, despair, disturbed sleep, headaches and emotional resistance.³¹³

CAMHS also find that [the son] presents with high risk of developmental harm and trauma related harm and that both parents suffer with symptoms of depression, anxiety and suicidal ideation. CAMHS recommends that the whole family be urgently released from detention, specifically stating that:

CAMHS is of the opinion that it is not possible to treat post-traumatic stress, suicidality and depression within a detention centre environment.³¹⁴

Department Deputy Manager writes to a medical practitioner, requesting an assessment of the family for the purposes of an application for a bridging visa.³¹⁵ Family notified of ineligibility to apply for a bridging visa three days later.³¹⁶ The Inquiry did not receive a report of the medical assessment – it seems unlikely to have occurred within three days.

A last resort?

July 2002

Department Minute recommending the movement of the mother and children to the Woomera RHP sent to the First Assistant Secretary of the Department.³¹⁷

Report by a psychiatrist from the Women's and Children's Hospital, Adelaide (provided to the Department Manager on 8 July 2002) concludes that none of the family is treatable within the detention environment.³¹⁸ The following diagnoses are made in the report:

[The son] has regressed and developed anxiety symptoms and enuresis since exposure to violence in Woomera some months ago. His speech may also be delayed. [He] is not able to be treated within the detention environment...

[The mother] has symptoms of major depression despite supportive family therapy and several months treatment with appropriate medication. She has persistent insomnia, anhedonia, weepiness and a sense of hopelessness. [She] is not able to be treated within the detention environment...

[The father] has persisting symptoms of major depression and post traumatic stress disorder, despite treatment with appropriate medication and family support therapy for several months. [He] is not able to be treated in the detention environment...

[The eldest daughter] has symptoms of major depression and post traumatic stress disorder. Her suicidality is currently expressed by her participation in the hunger strike. Despite appropriate treatment with medication and several sessions of supportive family therapy, her symptoms persist. [She] is not able to be adequately treated in the detention environment...

[The younger daughter] has persisting symptoms of major depression and post traumatic stress disorder despite several months treatment with family therapy and appropriate medication. She is actively suicidal and is currently expressing this by her participation in the hunger strike. She is not able to be treated in the detention environment.

Psychiatrist concludes that the situation of this family represents a 'medical and psychiatric emergency':

The illness of both parents and both teenagers and the developmental and behavioural difficulties displayed by [the son] cannot be adequately addressed in the detention environment. This is in part because the detention environment, with constant exposure to the despair and self destructive acts of other residents, is the source of significant trauma to all members of this family.

It is extremely important for this family to remain together. There is a high risk that if the children were separated from their parents, or the mother and children separated from [the father], that this would increase the risk of suicide of one of the family members.

The father told the psychiatrist that:

during the time he was arrested and tortured in Iran the military there had threatened to bring his children in and make them watch him being tortured. He said 'This is what is happening now in Australia'.

Psychiatrist recommends that the family should be immediately removed from the detention context. She states that until this is possible they should be moved to live in the Woomera RHP.³¹⁹

The Department Deputy Manager questions the status of these reports in an email to Central Office, stating that:

[CAMHS] have not been asked to carry out assessments in relation to visa options. Nonetheless they have forwarded a copy of their report, to this office, stating that the family cannot be treated in the detention environment.³²⁰

30 July 2002

Mother and children are moved to the Woomera RHP.

August 2002

Paediatric report recommends son's removal from the detention environment:

I see this young man as having been exposed to a number of inappropriate adult behaviours. His static speech and language development and enuresis are most likely to come from post traumatic stress disorder. ... This young man needs continued skilled observation and his parents need to be in a situation in which they can provide him with security and protection from the traumas he has observed. ...

The ideal environment for this young man to settle would be a family home setting with appropriate social and other supports.³²¹

October 2002

Mother is referred to a psychiatrist by the doctor at Woomera Hospital. The referral notes that:

In summary it has been observed by various clinicians that the members of this family are suffering from severe mental illness. It has been recommended to the Department of Immigration by CAMHS that the family be removed from the detention environment. The move to Woomera Housing Project has been unsuccessful at preventing further deterioration of this family and in particular [the mother]. Prescription of medication and provision of supportive psychotherapy have also failed to prevent deterioration.³²²

November 2002

By early November, the mother returned to the Woomera centre to be with her husband.

A last resort?

ACM psychologist reports that all children have severe depression. One of the daughters is suicidal and the son has cognitive development problems. She reports that they cannot be treated in the detention environment.³²³

August 2003

Family released on a temporary protection visa after the intervention of the Minister.³²⁴

9.7.3 Case Study 3: History of self-harm by a 14-year-old boy in Woomera

This case study details the history of self-harm by a 14-year-old boy who was detained at Woomera on 26 April 2001 when he was 12-years-old.

11 April 2002

Child attempts to hang himself with a bed sheet on playground equipment. Taken to Woomera Base Hospital, returned immediately to Woomera. Placed on 2 minute observations and accommodated in an observation room at the medical centre. Father stays with him. FAYS notified.³²⁵

12 April 2002

Child's mother becomes very upset and is taken to Woomera Hospital for observations and assessment by psychologist. Says that she is on hunger strike.³²⁶

Child recorded as saying:

he wanted to kill himself because his mother doesn't eat and she cries all the time. 'If I go back to camp I have every intention of killing myself. I'll do it again and again'. Very tired of camp, getting up in the morning and seeing the fences and dirt. 'We came for support and it seems we're being tortured. It doesn't matter where you keep me, I'm going to hang myself'.³²⁷

'[Child] stated that he would continue to try to kill himself until he was successful as he could no longer tolerate detention. Placed in [medical] observation with permission of and in the company of father'.³²⁸

13 April 2002

Child says that he wants to leave the medical observation room and return to compound with his father. He says that he will not make any further 'attempts to hurt himself or threats of self-harm'. Returns to compound on 15 minute observations.³²⁹

14 April 2002

Child tells officers that he is going to hang himself. Child and his father return to the medical centre.³³⁰

15 April 2002

Child tells officer 'You have three choices, either you kill me, I kill myself, or give me a VISA'.³³¹

17 April 2002

Child returns to the compound.³³²

19 April 2002

Child attempts to hang himself from playground equipment. Child taken to Woomera Hospital with his father.³³³

21 April 2002

Child returns to Woomera, on 15 minute observations.

8 May 2002

Child threatens self-harm:

He had threatened to self harm either by hanging or drinking shampoo. He was informed that his safety was in his control and that by hurting himself does not alter the situation. Due to previous impulsive behaviours decision made to place him on 30 min HRAT observations.³³⁴

17 May 2002

Child attempts to hang himself from playground equipment. Taken to Woomera Hospital and then returns to the compound. FAYS notified.³³⁵

22 May 2002

Officer reports the child said that:

today is his last day. Told me tonight will be the end, his last night alive.³³⁶

30 May 2002

Psychiatrist reports that:

For [this child] the matter is simple. If he remains in custody he wishes to die. He can no longer bear the razor wire and dirt. He worries about his mother's wellbeing and also about his father who he says is constantly worrying and angry. He has not been going to school, although there has recently been an opportunity to do so, because leaving the compound increases his distress on his return.

[He] has significant neurovegetative changes with sleep disturbance, loss of concentration, appetite, interest and energy. He may also have lost some weight. He is seriously suicidal, maintaining that he has plans to kill himself in the next few days. He would not elaborate, saying that he did not wish to give any hints which might lead to him being prevented from killing himself. He has no significant anxiety symptoms with his predominant affect being one of anger. He experiences hypnagogic auditory hallucinations in bed at night of voices telling him to kill himself. There were no other symptoms suggestive of psychosis.

[He] meets criteria for major depressive disorder. More importantly, he is an acute and serious suicide risk. [His] suicidal intent is closely related to whether or not he is in detention.³³⁷

31 May 2002

Child reported as being 'happy about visiting his mother [in hospital] on weekend, wanted phone call to mother but told he had one yesterday'.³³⁸

A last resort?

7 June 2002

Child found in the razor wire. He says 'he can't go on anymore'.³³⁹

8 June 2002

Child found in the razor wire again.³⁴⁰

14 June 2002

Child climbs fence into the razor wire a third time. After about eight minutes he climbs down again.³⁴¹

24 June 2002

Child on hunger strike.³⁴²

30 June 2002

Child makes superficial slashes on left forearm. 'Action generated by demand to see mother in hospital – previously refused – not due to depression or suicidal intent'. Incident report states that a visit to the mother is arranged as soon as possible.³⁴³

8 July 2002

Child on hunger strike.³⁴⁴

13 July 2002

Child found in razor wire.³⁴⁵

26 July 2002

Child attempts to hang himself.³⁴⁶

29 July 2002

Child smashes lights in dining area, slashes arm with fluorescent tube.³⁴⁷ A FAYS report on this incident notes the following:

On 29 July 2002 [the child] was observed to be in an agitated state. On arriving at the mess [he] upturned tables and threw chairs around. He broke one of the lights and cut himself 5 times with the shards of tubing. [He] told medical staff that he did this because he was prevented from seeing his mother [who was in hospital] over the weekend. **Visits outside had been cancelled that weekend due to protester activity outside of the centre.** [He] had been advised of another time made to visit his mother but this did not prevent his distress [emphasis in original].³⁴⁸

January 2003

Child transferred to Woomera RHP.

December 2003

Child in detention at the Port Augusta RHP.

Endnotes

- 1 See further Chapter 2 on Methodology.
- 2 UNHCR, *Refugee Children: Guidelines on Protection and Care* (UNHCR Guidelines on Refugee Children), Geneva, 1994, ch 4, VII.
- 3 Committee on the Rights of the Child, *General guidelines regarding the form and contents of periodic reports to be submitted by States Parties under article 44, paragraph 1(b) of the Convention*, 20 November 1996, UN Doc CRC/C/58, para 40.
- 4 *C v Australia*, Communication No 900/1999, 31 November 2002, UN Doc CCPR/C/76/D/900/1999, para 8.4.
- 5 UNHCR Guidelines on Refugee Children, ch 4.
- 6 *United Nations Rules for the Protection of Juveniles Deprived of their Liberty* (the JDL Rules), Geneva, 1990, rule 1.
- 7 The JDL Rules, rule 21(e).
- 8 The JDL Rules, rule 31.
- 9 The JDL Rules, rule 12.
- 10 The JDL Rules, rule 52.
- 11 The JDL Rules, rule 28.
- 12 DIMIA, Managers' Handbook, Section 5.1, Issue 3, 30 April 2002, para 11.
- 13 ACM, Response to Draft Report, 15 August 2003.
- 14 DIMIA, Submission 185, pp63-64.
- 15 IDS, 1998, paras 4.1-4.5, www.immi.gov.au/detention/det_standards.htm.
- 16 IDS, 1998, para 2.1.
- 17 IDS, 1998, para 5.5.
- 18 IDS, 1998, para 6.2.3.
- 19 IDS, 1998, para 6.2.4.
- 20 IDS, 1998, para 8.3.1.
- 21 IDS, 1998, paras 9.6.1, 9.6.2.
- 22 ACM, Health Services Operating Manual, Policy 4.0, Psychiatric Services, Issue 2, 9 May 2002, paras 1.1-1.2, (N1, Q8, F9).
- 23 ACM, Health Services Operating Manual, Policy 2.1, Initial Health Assessment, Issue 2, 20 August 2002, para 4.3. ACM, Response to Draft Report, 15 August 2003.
- 24 ACM, Policy 7.1, At Risk/Self Harm/Suicide Management, Issue 5, 18 April 2002, para 1.1.
- 25 ACM, Health Services Operating Manual, Policy 4.1, Referral of a Detainee to a Psychiatric Centre, Issue 2, 9 May 2002, para 4.1, (N1, Q8, F9).
- 26 ACM, Health Services Operating Manual, Policy 4.1, Referral of a Detainee to a Psychiatric Centre, Issue 2, 9 May 2002, para 4.4, (N1, Q8, F9).
- 27 ACM, Health Services Operating Manual, Policy 4.3, Suicide Prevention, Issue 2, 9 May 2002, para 3.1, (N1, Q8, F9).
- 28 ACM, Health Services Operating Manual, Policy 4.3, Suicide Prevention, Issue 2, 9 May 2002, para 4.1, (N1, Q8, F9).
- 29 ACM, Policy 7.1, At Risk/Self Harm/Suicide Management, Issue 5, 18 April 2002; , Health Services Operating Manual, Policy 4.3, Suicide Prevention, Issue 2, 9 May 2002.
- 30 ACM, Policy 7.1, At Risk/Self Harm/Suicide Management, Issue 5, 18 April 2002, paras 4.5, 4.11.
- 31 ACM, Policy 7.1, At Risk/Self Harm/Suicide Management, Issue 5, 18 April 2002, para 4.21.
- 32 ACM, Policy 6.9, Voluntary Starvation, Issue 3, 27 June 2002.
- 33 ACM, Policy 6.9, Voluntary Starvation, Issue 3, 27 June 2002, Management of Children on Hunger Strike.
- 34 ACM, Policy 6.9, Voluntary Starvation, Issue 3, 27 June 2002, Management of Children on Hunger Strike.
- 35 DIMIA, Submission 185, p92.
- 36 DIMIA, Letter to Inquiry, 22 November 2002, Attachment 2, Clarification regarding the application of State and Territory laws in immigration detention facilities.
- 37 DIMIA, Letter to Inquiry, 22 November 2002, Attachment 2, Clarification regarding the application of State and Territory laws in immigration detention facilities.
- 38 DHS, Transcript of Evidence, Adelaide, 1 July 2002, p79.
- 39 See for example, Bertram A Akhurst, 'The effects of long stay care', vol 2, no 3, *Australian Social Welfare*, 1972, pp27-30; J & S Bloom-Fleshbach, *The Psychology of Separation and Loss*, Jersey

A last resort?

- Bass, San Francisco, 1988; evidence presented to the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families.
- 40 See for example, CMD Zeanah, 'Disturbances of Attachment in Young Children Adopted from Institutions', *Developmental and Behavioural Pediatrics*, vol 21, no 3, June 2000; ML Rutter, JM Kreppner, and TG O'Connor, 'Specificity and heterogeneity in children's responses to profound institutional privation', *British Journal of Psychiatry*, vol 179, August 2001, pp97-103.
- 41 Senate Community Affairs References Committee, *Lost Innocents: Righting the Record: Report on Child Migration*, August 2001.
- 42 Government of Queensland, *Commission of Inquiry into Abuse of Children in Queensland Institutions*, 1999, ch 12.
- 43 ACM, Response to Draft Report, 31 July 2003.
- 44 Alliance of Health Professionals, Submission 109, p13.
- 45 Z Steel, S Momartin, C Bateman, A Hafshejani, D Silove, N Everson, JK Salehi, K Roy, M Dudley, L Newman, B Blick, S Mares, S Raman, J Everett. 'Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia', in Z Steel, *The politics of exclusion and denial the mental health costs of Australia's refugee policy*, Keynote address, 38th Congress Royal Australian and New Zealand College of Psychiatrists, Hobart, 12-15 May, 2003, p20. This report considered 20 children. One of the children was not interviewed directly, but agreed to his mother being interviewed about his experiences.
- 46 See further Chapter 3, Setting the Scene, for statistics regarding children in immigration detention.
- 47 T Thomas and W Lau, 'Psychological Wellbeing of Child and Adolescent Refugee and Asylum Seekers, Overview of Major Research Findings of the Past Ten Years', Inquiry Research Paper, 2002.
- 48 Thomas and Lau, 2002, p14.
- 49 AAIMH, Submission 29, p3. See also Coalition Assisting Refugees After Detention (CARAD), Transcript of Evidence, Perth, 10 June 2002, p26; Victorian Foundation for Survivors of Torture (VFST), Submission 184, pp2-3; Kids in Detention Story, Submission 196, Mental Health Section, pp7-8.
- 50 Western Young People's Independent Network and Catholic Commission for Justice Development and Peace, Submission 199, p34 citing Patrick McGorry, 'Asylum seeking and mandatory detention', *Australian Family Physician*, Vol 31, no 3, March 2002, pp275-77.
- 51 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p69.
- 52 See, for example, WH Sack, C Him and D Dickson, 'Twelve-year follow-up study of Khmer youths who suffered massive war trauma as children', *Journal of the American Academy of Child & Adolescent Psychiatry*, vol 38, September 1999, pp1173-79; K Almqvist and M Brandell-Forsberg, 'Refugee children in Sweden: post-traumatic stress disorder in Iranian preschool children exposed to organised violence', *Child Abuse & Neglect*, vol 21, no 4, April 1997, pp351-66.
- 53 Steel et al, p10. See also Z Steel and Derrick M Silove, 'The mental health implications of detaining asylum seekers', *Medical Journal of Australia*, vol 175, 2001, pp596-599.
- 54 Migrant & Workers Resource Centre, Refugee Assessment Project, Inquiry Research Paper, p7.
- 55 Dr Jon Jureidini, Transcript of Evidence, Adelaide, 2 July 2002, p43.
- 56 See Chapter 3, Setting the Scene, for detailed statistics regarding children in immigration detention.
- 57 DIMIA, Contract Operations Group Minutes, 19 July 2001, (N1, Q3, F4).
- 58 DIMIA Woomera, Manager Report, May 2002, (N1, Q3a, F5).
- 59 ACM, Response to Draft Report, 15 August 2003.
- 60 Inquiry, Focus group, Perth, June 2002.
- 61 VFST, Submission 184, p5 citing McCallin, 'Living in Detention: A review of the psychosocial well-being of Vietnamese children in the Hong Kong Detention Centres' Report, prepared for the International Child Catholic Bureau Geneva, 1992.
- 62 DHS, Transcript of Evidence, Adelaide, 1 July 2002, p82; MWRC, Refugee Assessment Project, Inquiry Research Paper, p8.
- 63 Dr Annie Sparrow, Transcript of Evidence, Perth, 10 June 2002, p68.
- 64 Harold Bilboe, Transcript of Evidence, Sydney, 16 July 2002, p40.
- 65 DIMIA, Response to the Draft Report, 10 July 2003.
- 66 ACM emphasised to the Inquiry that they are not able to remedy any of the factors connected to visa processing. ACM, Response to Draft Report, 15 August 2003.
- 67 Dr Bernice Pfitzner, Transcript of Evidence, Sydney, 16 July 2002, pp6-7.
- 68 A Sultan and K O'Sullivan, 'Psychological disturbances in asylum seekers held in long term detention: a participant-observer account', *Medical Journal of Australia*, vol 175, 2001.
- 69 Sultan and O'Sullivan, 2001.

- 70 Dr Annie Sparrow, Transcript of Evidence, Perth, 10 June 2002, p65. See also Dr Bernice Pfitzner, Transcript of Evidence, Sydney, 16 July 2002, p5.
- 71 DHS, Woomera Detention Centre Assessment Report, 12 April 2002, Submission 181a, pp6-7.
- 72 DIMIA, Response to Draft Report, 10 July 2003.
- 73 Commonwealth Department of Health and Ageing, National Mental Health Strategy, *Promotion, Prevention and Early Intervention for Mental Health*, 2000.
- 74 AAIMH, Transcript of Evidence, Adelaide, 1 July 2002, p30.
- 75 AAIMH, Transcript of Evidence, Adelaide, 1 July 2002, pp27-28.
- 76 Dr Jon Jureidini, Transcript of Evidence, Adelaide, 2 July 2002, p40.
- 77 DHS, Woomera Detention Centre Assessment Report, 12 April 2002, Submission 181a, p10.
- 78 DHS, Woomera Detention Centre Assessment Report, 12 April 2002, Submission 181a, p10.
- 79 ACM, Response to Draft Report, 15 August 2003.
- 80 Harold Bilboe, Submission 268, para 44. See also CARAD, Transcript of Evidence, Perth, 10 June 2002, p28; Alliance of Health Professionals, Submission 109, pp20, 28.
- 81 Alliance of Health Professionals, Submission 109, p28.
- 82 Dr Sarah Mares, Transcript of Evidence, Adelaide, 2 July 2002, p41.
- 83 DHS, Social Work Assessment Report on the Circumstances of Children in the Woomera Immigration & Processing Centre, 21 August 2002, p7, (N5, Case 18, p78).
- 84 Dr Sarah Mares, Transcript of Evidence, Adelaide, 2 July 2002, p46.
- 85 Child Protection Service, Flinders Medical Centre, Psychological Assessment Report, 18 September 2002.
- 86 A further two adult daughters and their husbands were detained at Woomera too, but they were found to be refugees and were released on temporary protection visas in late 2001.
- 87 Senior Child Psychiatrist, Department of Psychological Medicine, Women's & Children's Hospital, Adelaide, Psychiatric Report, 30 May 2002, (N3, F9).
- 88 Senior Child Psychiatrist, Department of Psychological Medicine, Women's & Children's Hospital, Adelaide, Psychiatric Report, 30 May 2002, (N3, F9).
- 89 Senior Child Psychiatrist, Department of Psychological Medicine, Women's & Children's Hospital, Adelaide, Psychiatric Report, 30 May 2002, (N3, F9).
- 90 NSW Guardianship Tribunal, Limited Guardianship Order, Reasons for Decision, 30 May 2002, pp6-7, (N5, Case 33, pp19-20).
- 91 NSW Guardianship Tribunal, Limited Guardianship Order, Reasons for Decision, 30 May 2002, p7, (N5, Case 33, p20).
- 92 NSW Guardianship Tribunal, Limited Guardianship Order, Reasons for Decision, 30 May 2002, pp7-8, (N5, Case 33, pp20-21).
- 93 NSW Guardianship Tribunal, Limited Guardianship Order, Reasons for Decision, 30 May 2002, p10, (N5, Case 33, p23).
- 94 NSW Guardianship Tribunal, Limited Guardianship Order, Reasons for Decision, 30 May 2002, p10, (N5, Case 33, p23).
- 95 NSW Guardianship Tribunal, Limited Guardianship Order, Reasons for Decision, 30 May 2002, p11, (N5, Case 33, p24).
- 96 Inquiry, Interview with Office of the NSW Public Guardian, Sydney, 1 May 2003.
- 97 NSW Guardianship Tribunal, Limited Guardianship Order, Reasons for Decision, 30 May 2002, pp14-15, (N5, Case 33, pp27-28).
- 98 A Woomera incident report noted that the mother had 'made threats to the kill her children and herself if the family does not get a visa'. ACM Woomera, Incident Report, WMIRPC 362/02, 3 May 2002, (N3, F10).
- 99 ACM Woomera Registered Nurse, Memo, to ACM Operations, 10 May 2002, (N3, F9). ACM Woomera, Nurse Reports re the Care of the [name deleted] family, 9-15 May 2002, (N3, F9).
- 100 ACM Woomera, Nurse Reports re the Care of the [name deleted] family, 9-15 May 2002, (N3, F9).
- 101 DHS, FAYS, Internal Memorandum, Actions by DIMIA at the Woomera Detention Centre in relation to the [name deleted] family, 13 May 2002, (N2, Q7, F6).
- 102 ACM Woomera, Medical Records, 7 May 2002, (N3, F8).
- 103 DHS, FAYS, Internal Memorandum, Actions by DIMIA at the Woomera Detention Centre in relation to the [name deleted] family, 13 May 2002, (N2, Q7, F6). See also ACM Woomera, Nurse Reports re the Care of the [name deleted] family, 9-15 May 2002, 8 May 2002, (N3, F9).
- 104 ACM Woomera, Nurse Reports re the Care of the [name deleted] family, 9-15 May 2002, 12 May 2002, (N3, F9).

A last resort?

- 105 DHS, FAYS, Internal Memorandum, Actions by DIMIA at the Woomera Detention Centre in relation to the [name deleted] family, 13 May 2002, (N2, Q7, F6).
- 106 Royal Australian New Zealand College of Psychiatrists, Transcript of Evidence, Sydney, 17 July 2002, p59.
- 107 Inquiry, Focus group, Perth, June 2002.
- 108 Inquiry, Interview with detainee, Villawood, August 2002.
- 109 ACM Woomera, Detention Officer Report, 3 May 2002, (N3, F9).
- 110 Clinical Director, Royal Adelaide Hospital, Glenside Campus Mental Health Service, Psychiatric Report, 26 July 2002, (N5, Case 28, 699).
- 111 ACM, Response to Draft Report, 15 August 2003.
- 112 Unaccompanied child, quoted in MWRC, Refugee Assessment Project, Inquiry Research Paper, p35.
- 113 Inquiry, Interview with detainee, Woomera, June 2002.
- 114 Inquiry, Interview with detainee, Baxter, December 2002.
- 115 DHS, Woomera Detention Centre Assessment Report, 12 April 2002, Submission 181a, p8.
- 116 DHS, Social Work Assessment Report on the Circumstances of Children in the Woomera Immigration & Processing Centre, 21 August 2002, pp12-13, (N5, Case 18, pp83-84).
- 117 Sultan and O'Sullivan, 2001.
- 118 Dr Sarah Mares, Transcript of Evidence, Adelaide, 2 July 2002, p40.
- 119 DHS, Woomera Detention Centre Assessment Report, 12 April 2002, Submission 181a, p13.
- 120 Inquiry, Interview with detainee mother, Port Hedland, June 2002.
- 121 Inquiry, Interview with detainee father, Port Hedland, June 2002.
- 122 Inquiry, Interview with detainee mother, Woomera, June 2002.
- 123 DIMIA, Response to Draft Report, 10 July 2003.
- 124 ACM, Response to Draft Report, 15 August 2003.
- 125 Dr Marie O'Neill, Submission 252, para 21.
- 126 Philip Flood, *Report of Inquiry into Immigration Detention Procedures* (Flood Report), February 2001, p41.
- 127 DHS, Social Work Assessment Report on the Circumstances of Children in the Woomera Immigration & Processing Centre, 21 August 2002, p8, (N5, Case 18, p79).
- 128 Inquiry, Interview with detainee, Woomera, January 2002.
- 129 Inquiry, Interview with detainee, Woomera, January 2002.
- 130 ChilOut, Submission 120, p13.
- 131 Inquiry, Focus group, Sydney, March 2002.
- 132 DIMIA Port Hedland, Manager Report, October-December 2000, (N1, Q4A, Attachment A).
- 133 Inquiry, Focus group, Melbourne, May 2002.
- 134 DHS, Woomera Detention Centre Assessment Report, 12 April 2002, Submission 181a, p12.
- 135 Mark Huxstep, Submission 248, p3.
- 136 Flood Report, February 2001, p28.
- 137 ACM, Response to Draft Report, 15 August 2003.
- 138 See Minister for Immigration and Multicultural and Indigenous Affairs, Border Protection, Report of Inquiry into Immigration Detention Procedures, Government's Specific Responses to Flood Report Recommendations, at http://www.minister.immi.gov.au/borders/detention/inquiry_response2.htm, viewed 3 September 2003.
- 139 Katie Brosnan, Transcript of Evidence, Perth, 10 June 2002, p18.
- 140 Inquiry, Focus group, Perth, June 2002.
- 141 MWRC, Refugee Assessment Project, Inquiry Research Paper, p36.
- 142 Inquiry, Interview with detainees, Baxter, December 2002.
- 143 ACM, Response to Draft Report, 15 August 2003.
- 144 7:30 Report, ABC television, 10 April 2002, at <http://www.abc.net.au/7.30/s528366.htm>, viewed 19 December 2003. See also Lateline, ABC television, 6 June 2002, at <http://www.abc.net.au/lateline/s575825.htm>, viewed 19 December 2003.
- 145 Sharon Torbet, Submission 62a, para 11.
- 146 Confidential Submission, 242a, p5.
- 147 ACM, Detention Services Monthly Report, August 2002, (ACM N4).
- 148 DIMIA, Response to Draft Report, 10 July 2003.
- 149 Sultan and O'Sullivan, 2001.
- 150 Steel et al, 2003, pp10-11.
- 151 The study notes as a strength that 'the assessments were carried out using international validated psychiatric diagnostic instruments with ratings independently made by three same language

speaking psychologists all with previous experience of assessing refugee adults and children'. The study also acknowledges a number of limitations. For example, it notes that the retrospective reports on psychiatric disturbance prior to detention may have been affected by the passage of time; however, it also notes that the rates of premigration mental illness reported by the adults were similar to rates identified in other post-conflict populations. The study also notes that 'a number of the measures employed to assess detention symptoms and parenting capacity were developed specifically for this study and have not been independently validated'; however, the core measures used to assess for the presence of mental illness in children and adults were based on assessments using internationally validated diagnostic measures. The report does acknowledge the possibility that the respondents may have exaggerated reports of experiences and symptoms, but concludes that consistency in reports made by different families, as well as consistency in reports made by children and their parents interviewed separately suggest that this may be limited. In addition to the summary evidence provided to the Commission, the researchers forwarded detailed psychological reports relating to each of the families assessed for this study on a confidential basis. Those reports support the conclusions of the study.

- 152 Physicians for Human Rights and the Bellevue/NYU Program for Survivors of Torture, *From Persecution to Prison: The Health Consequences of Detention for Asylum Seekers*, June 2003.
- 153 Child and Adolescent Psychiatrist, Department of Psychological Medicine, Women's and Children's Hospital, Adelaide, Summary of Children and Families in Woomera Referred to and Assessed by Child and Adolescent Mental Health Services, January to July 2002, p1, (N5, Case 22, pp10-22). Members from ten families who had been detained in Woomera for between 16 and 20 months were assessed. ACM informed the Inquiry that during these six months there was an average of 109 children detained at Woomera. ACM, Response to Draft Report, 15 August 2003.
- 154 Child and Adolescent Psychiatrist, Department of Psychological Medicine, Women's and Children's Hospital, Adelaide, Summary of Children and Families in Woomera Referred to and Assessed by Child and Adolescent Mental Health Services, January to July 2002, pp2-3, (N5, Case 22, pp14-15).
- 155 Dr Sarah Mares and Dr Jon Jureidini, 'Children and Families Referred from a Remote Immigration Detention Centre', paper presented at *Forgotten Rights – Responding to the Crisis of Asylum Seeker Health Care, A National Summit*, NSW Parliament House, 12 November 2003. This study probably includes some of the children in the table above as they were referred to CAMHS during the same period of time.
- 156 ACM, Response to Draft Report, 17 October 2003.
- 157 Primary records from an ACM psychologist and DHS suggest that two of the children who ACM reported did not have depression, did in fact suffer that mental illness. Similarly, ACM did not identify a third child with depression despite the fact that ACM medical records themselves indicate that the child was diagnosed and medicated for depression. In the case of a fourth child who was diagnosed by a psychiatrist as suffering from PTSD, ACM reported that he was suffering from depression, but not PTSD. A fifth child diagnosed as experiencing developmental delay by DHS was not identified by ACM.
- 158 DIMIA Woomera, Manager Report, May 2002, (N1, Q3A, F5).
- 159 AAIMH, Transcript of Evidence, Adelaide, 1 July 2002, p26.
- 160 Royal Australian New Zealand College of Psychiatrists, Transcript of Evidence, Sydney, 17 July 2002, pp52-53. See also National Investment for the Early Years, Submission 96; AAIMH, Submission 29, pp7-10; Alliance of Health Professionals, Submission 109, pp6-7; Kids in Detention Story, Submission 196, Mental Health Section, p2.
- 161 DHS, Submission 181, p17.
- 162 Senior Child Psychiatrist, Department of Psychological Medicine, Women's & Children's Hospital, Adelaide, Psychiatric Report, 30 May 2002, (N3, F9).
- 163 Dr Annie Sparrow, Transcript of Evidence, Perth, 10 June 2002, p64.
- 164 Inquiry, Interview with detainee family, Woomera, June 2002.
- 165 Inquiry, Interview with detainee, Woomera, September 2002.
- 166 DHS, Woomera Detention Centre Assessment Report, 12 April 2002, Submission 181a, pp18-19.
- 167 DHS, Woomera Detention Centre Assessment Report, 12 April 2002, Submission 181a, p20.
- 168 Inquiry, Interview with detainee father, Curtin, June 2002.
- 169 Inquiry, Interview with detainee father, Curtin, June 2002.
- 170 Inquiry, Interview with detainee father, Curtin, June 2002.
- 171 Inquiry, Interview with detainee family, Woomera, June 2002.
- 172 The Department noted that 'Baxter families are generally relatively long-term detainees whose initial applications for visas have been rejected'. DIMIA, Response to Draft Report, 10 July 2003.

A last resort?

- 173 Inquiry, Interview with detainee mother, Baxter, December 2002.
- 174 Inquiry, Interview with detainee mother, Baxter, December 2002.
- 175 Steel et al, 2003, p10. See also Sultan and O'Sullivan, 2001, who found that of 33 adult detainees who had been detained over nine months, all but one had displayed symptoms of psychological distress at some time during their detention and that 85 per cent acknowledged chronic depressive symptoms, with 65 per cent having pronounced suicidal ideation.
- 176 Child and Adolescent Psychiatrist, Department of Psychological Medicine, Women's and Children's Hospital, Adelaide, Summary of Children and Families in Woomera Referred to and Assessed by Child and Adolescent Mental Health Services, January to July 2002, p2. (N5, Case 22, p14).
- 177 Barbara Rogalla, Transcript of Evidence, Melbourne, 30 May 2002, p33.
- 178 Dr Annie Sparrow, Transcript of Evidence, Perth, 10 June 2002, p63.
- 179 Dr Annie Sparrow, Transcript of Evidence, Perth, 10 June 2002, p65.
- 180 Dr Annie Sparrow, Transcript of Evidence, Perth, 10 June 2002, p65.
- 181 Dr Annie Sparrow, Transcript of Evidence, Perth, 10 June 2002, p66.
- 182 ACM Woomera Psychologist, Letter, to DHS, FAYS Director, 8 November 2002.
- 183 DHS, Woomera Detention Centre Assessment Report, 12 April 2002, Submission 181a, p14.
- 184 ACM Woomera, Psychological Report, to DIMIA Manager, 4 December 2001, (N3, F4).
- 185 DHS, Woomera Detention Centre Assessment Report, 12 April 2002, Submission 181a, p9.
- 186 Child Protection Service, Flinders Medical Centre, Psychological Assessment Report, 18 September 2002, p14.
- 187 Child Protection Service, Flinders Medical Centre, Psychological Assessment Report, 18 September 2002, p14.
- 188 Senior Child Psychiatrist, Department of Psychological Medicine, Women's & Children's Hospital, Adelaide, Psychiatric Report, 30 May 2002, (N3, F9).
- 189 Child and Adolescent Psychiatrist, Department of Psychological Medicine, Women's and Children's Hospital, Adelaide, Summary of Children and Families in Woomera Referred to and Assessed by Child and Adolescent Mental Health Services, January to July 2002, p2. (N5, Case 22, p14).
- 190 Lyn Bender, Transcript of Evidence, Melbourne 31 May 2002, pp3-4.
- 191 Inquiry, Interview with detainees, Curtin, June 2002.
- 192 Inquiry, Focus group, Sydney, March 2002.
- 193 Inquiry, Focus group, Sydney, March 2002.
- 194 Inquiry, Focus group, Perth, June 2002.
- 195 DHS, Woomera Detention Centre Assessment Report, 12 April 2002, Submission 181a, p12.
- 196 Inquiry, Interview with detainee, Curtin, June 2002.
- 197 Inquiry, Interview with detainee, Woomera, June 2002.
- 198 AAIMH, Transcript of Evidence, Adelaide, 1 July 2002, p31.
- 199 Inquiry, Interview with detainee, Woomera, June 2002.
- 200 Inquiry, Interview with detainee mother, Woomera, January 2002.
- 201 Inquiry, Interview with detainee father, Curtin, June 2002.
- 202 Inquiry, Interview with detainee, Curtin, June 2002.
- 203 Inquiry, Interview with detainee, Curtin, June 2002.
- 204 DHS, Transcript of Evidence, Adelaide, 1 July 2002, p77. See also DHS, Social Work Assessment Report on the Circumstances of Children in the Woomera Immigration & Processing Centre, 21 August 2002, p6, (N5, Case 18, p77), which states that incidents that have given rise to child protection reports relate primarily to three areas: involvement by the children in hunger strikes; harm or risk of harm to the children due to parental depression, mental illness or stress; and self-harm and threats of self-harm/suicide attempts by the children.
- 205 DHS, FAYS Assessment Report Relating to Afghani Unattached Minors, 28 January 2002, (N2, Q7, F6).
- 206 Inquiry, Interviews with ACM Centre Manager and Health Services Coordinator, Woomera, January 2002; ACM, Woomera, Medical Incident Reports relating to children for the period to 13 January 2002 to 29 January 2002; ACM record of all persons on observation as at 29 January 2002. See also Chapter 8 on Safety.
- 207 DHS, FAYS officer, Email to DIMIA Central Office, 14 June 2002, 3.12pm; DHS, FAYS officer, Email to DIMIA Central Office, 14 June 2002, 6.15pm, (N2, Q7, F6).
- 208 DHS, FAYS classification of child protection cases requiring investigation. 'A Tier 1 response classification is given to children and young people assessed as being in danger at the time of the notification. Some cases falling into the Tier 1 range include reports of major injuries, severe physical abuse of younger children, current intra-familial abuse, life-threatening neglect and abandonment'.

- R Layton QC, *Our Best Investment: A State Plan to Protect and Advance the Interests of Children*, Government of South Australia, 2003, chap 9.
- 209 DHS, FAYS classification of child protection cases requiring investigation. 'Reports assessed as Tier 2 involved children and young people who are at high or moderate risk of significant harm. Cases include serious physical, sexual and emotional abuse and neglect of young children, as well as vulnerable young people at high risk'. R Layton QC, *Our Best Investment: A State Plan to Protect and Advance the Interests of Children*, Government of South Australia, 2003, chap 9.
- 210 ACM informed the Inquiry that this child reported that he had engaged in self-harm prior to arriving in Australia. ACM also suggests that the suicide attempts were threats or gestures rather than serious attempts and that there was a correlation between the self-harm with DIMIA events and decisions. ACM also state that the claim that the child overdosed on medication is not supported by pathology results. ACM, Response to Draft Report, 15 August 2003.
- 211 DHS, Social Work Assessment Report on the Circumstances of Children in the Woomera Immigration & Processing Centre, 21 August 2002, p6, (N5, Case 18, p77).
- 212 Inquiry, Interview with detainee, Woomera, June 2002.
- 213 Anita Chauvin, Submission 294, p2.
- 214 Royal Australian New Zealand College of Psychiatrists, Transcript of Evidence, Sydney, 17 July 2002, p60. See also AAIMH, Transcript of Evidence, Adelaide, 1 July 2002, p32.
- 215 DIMIA, Submission 185, p59.
- 216 ACM, Health Services Operating Manual, Policy 2.1, Initial Health Assessment, Issue 2, 20 August 2002. ACM, Response to Draft Report, 15 August 2003.
- 217 ACM Curtin, Medical Records, 14 May 2001 (N5, Case 5, p1); ACM Port Hedland, Medical Records, Undated (N5, Case 8, p95).
- 218 Dr Marie O'Neill, Submission 252, para 10. See also Barbara Rogalla, Transcript of Evidence, Melbourne, 30 May 2002, pp35-36.
- 219 DIMIA, Response to Draft Report, 10 July 2003.
- 220 See Chapter 3, Setting the Scene, for further statistics.
- 221 DIMIA Curtin, Manager Report, April 2002, (N1, Q3A, F5).
- 222 DIMIA Port Hedland, Manager Report, April 2002, (N1, Q3A, F5).
- 223 DIMIA Port Hedland, Manager Report, May 2002, (N1, Q3A, F5).
- 224 DIMIA, Contract Operations Group Minutes, 23 May 2002, (N1, Q3, F4).
- 225 DHS, Social Work Assessment Report on the Circumstances of Children in the Woomera Immigration & Processing Centre, 21 August 2002, p3, (N5, Case 18, p74).
- 226 DHS, Social Work Assessment Report on the Circumstances of Children in the Woomera Immigration & Processing Centre, 21 August 2002, pp20-21, (N5, Case 18, pp91-92).
- 227 DHS, Social Work Assessment Report on the Circumstances of Children in the Woomera Immigration & Processing Centre, 21 August 2002, p11, (N5, Case 18, p82).
- 228 Dr Annie Sparrow, Transcript of Evidence, Perth, 10 June 2002, p66.
- 229 Dr Marie O'Neill, Submission 252, para 6.
- 230 NSW Guardianship Tribunal, Limited Guardianship Order, Reasons for Decision, 30 May 2002, p11, (N5, Case 33, p24).
- 231 DIMIA, Response to Draft Report, 10 July 2003; ACM, Response to the Draft Report, 15 August 2003.
- 232 DIMIA Port Hedland, Manager Report, March 2002, (N1, Q3A, F5).
- 233 DIMIA Woomera, Manager Report, April 2002, (N1, Q3A, F5).
- 234 DHS, Transcript of Evidence, Adelaide, 1 July 2002, p81.
- 235 Inquiry, Interview with detainee mother, Curtin, June 2002.
- 236 ACM, Response to Draft Report, 15 August 2003.
- 237 ACM, Response to Draft Report, 15 August 2003.
- 238 ACM, Response to Draft Report, 15 August 2003.
- 239 DHS, Social Work Assessment Report on the Circumstances of Children in the Woomera Immigration & Processing Centre, 21 August 2002, pp11-12, (N5, Case 18, pp82-83).
- 240 DHS, Social Work Assessment Report on the Circumstances of Children in the Woomera Immigration & Processing Centre, 21 August 2002, p21, (N5, Case 18, p92).
- 241 DHS, Social Work Assessment Report on the Circumstances of Children in the Woomera Immigration & Processing Centre, 21 August 2002, pp18-19, (N5, Case 18, pp89-90).
- 242 Child and Adolescent Psychiatrist, Department of Psychological Medicine, Women's and Children's Hospital, Adelaide, Summary of Children and Families in Woomera Referred to and Assessed by Child and Adolescent Mental Health Services, January to July 2002, (N5, Case 22, pp15-16).

A last resort?

- 243 ACM, Response to Draft Report, 15 August 2003.
- 244 Child and Adolescent Psychiatrist, Department of Psychological Medicine, Women's and Children's Hospital, Adelaide, Summary of Children and Families in Woomera Referred to and Assessed by Child and Adolescent Mental Health Services, January to July 2002, (N5, Case 22, p13).
- 245 STARTTS, *Trauma changes adults but forms children – Protecting and healing child asylum seekers and refugees*, Discussion Paper, 2002, p5.
- 246 ACM, Response to Draft Report, 15 August 2003.
- 247 ACM, Response to Draft Report, 15 August 2003.
- 248 ACM, Response to Draft Report, 15 August 2003.
- 249 ACM, Response to Draft Report, 31 July 2003.
- 250 DIMIA, Submission 185, p65.
- 251 DIMIA, Response to Draft Report, 10 July 2003.
- 252 This is discussed further in Chapter 14 on Unaccompanied Children.
- 253 ACM, Response to Draft Report, 15 August 2003.
- 254 DIMIA, Response to Draft Report, 10 July 2003.
- 255 ACM Port Hedland, Medical Records, 22 February 2002, (N3, F20).
- 256 ACM Port Hedland, Medical Records, 25 February 2002, (N3, F20).
- 257 ACM Port Hedland, Medical Records, 1 March 2002, (N3, F20).
- 258 ACM, Response to Draft Report, 8 August 2003.
- 259 DIMIA, Response to Draft Report, 14 July 2003.
- 260 ACM, Response to Draft Report, 5 September 2003.
- 261 ACM Woomera, Medical Records, 10 May 2002, (N3, F5); ACM Woomera, HRAT Watch Log, 10 May 2002, (N3, F5); ACM Woomera, HRAT Treatment Plan Modifications, 11 May 2002, (N3, F5); ACM Woomera, HRAT Watch Log, 15 May 2002, (N3, F5).
- 262 DIMIA, Submission 185, p65.
- 263 ACM, Response to Draft Report, 15 August 2003.
- 264 Harold Bilboe, Transcript of Evidence, Sydney, 16 July 2002, p43.
- 265 Senior Child Psychiatrist, Department of Psychological Medicine, Women's & Children's Hospital, Adelaide, Psychiatric Report, 30 May 2002, (N3, F9).
- 266 Senior Child Psychiatrist, Department of Psychological Medicine, Women's & Children's Hospital, Adelaide, Psychiatric Report, 30 May 2002, (N3, F9).
- 267 Senior Child Psychiatrist, Department of Psychological Medicine, Women's & Children's Hospital, Adelaide, Psychiatric Report, 30 May 2002, (N3, F9).
- 268 ACM Woomera Psychologist, Letter, to DHS, FAYS Director, 8 November 2002.
- 269 DHS Mental Health Unit, Director, Mental Health Services and Programs, Internal Memorandum, to Executive Director, Social Justice and Country Division, 26 August 2002. Provided to DIMIA Central Office on 30 August 2002, (N5, Case 28, p107).
- 270 Western Australian Government, Transcript of Evidence, Perth, 10 June 2002, p48.
- 271 DHS, Transcript of Evidence, Adelaide, 1 July 2002, p81.
- 272 See further Chapter 14 on Unaccompanied Children, Case Study 3 and Chapter 6 on Australia's Detention Policy (section 6.4.2).
- 273 DIMIA Woomera Deputy Manager, Email, to DIMIA Central Office, 11 July 2002, (N5, Case 22, p42).
- 274 R Layton QC, *Our Best Investment: A State Plan to Protect and Advance the Interests of Children*, Government of South Australia, 2003, ch 22.
- 275 Child and Adolescent Psychiatrist, Department of Psychological Medicine, Women's and Children's Hospital, Adelaide, Summary of Children and Families in Woomera Referred to and Assessed by Child and Adolescent Mental Health Services, January to July 2002, p4, (N5, Case 22, p16).
- 276 DIMIA, Response to Draft Report, 10 July 2003.
- 277 DIMIA, Response to Draft Report, 10 July 2003.
- 278 Regarding unaccompanied children see section 6.4.2 in Chapter 6 on Australia's Detention Policy, and Case Study 3 in Chapter 14 on Unaccompanied Children).
- 279 The Inquiry notes that the United Nations Human Rights Committee has found that the failure to release a man from detention in similar circumstances was a breach of article 7 of the ICCPR, constituting cruel, inhuman or degrading treatment; see *C v Australia* discussed in section 9.1 above.
- 280 DHS, FAYS, Senior Practitioner, Social Worker, Crisis Response and Child Abuse Service, Investigation Report on Child Protection Intake from Woomera Detention Centre, 10 May 2002, p4 (N5, Case 28, p80).

- 281 ACM Woomera Registered Psychiatric Nurse, Memo, to DIMIA Woomera Deputy Manager, 20 May 2002, (N5, Case 28, pp172-173).
- 282 DIMIA Woomera Deputy Manager, Facsimile, to Medical Practitioner, 29 May 2002, (N5, Case 28, p85).
- 283 DHS, FAYS, Senior Practitioner, Child Response and Child Abuse Service, Report on Child Protection Intakes from Woomera Detention Centre, 6 June 2002, (N5, Case 28, pp83-84).
- 284 DIMIA Woomera Deputy Manager, Minute to ACM Centre Manager, 7 June 2002, (N5, Case 28, p66).
- 285 ACM Woomera Registered Psychologist, Memo, to DIMIA Woomera Deputy Manager, 18 June 2002, (N5, Case 28, p70).
- 286 ACM Woomera Acting Health Services Manager, Memo, to ACM Centre Manager, 8 July 2002, (N5, Case 28, p89).
- 287 Fellow in Child Psychiatry, Senior Clinical Psychologist, Department of Psychological Medicine, Women's and Children's Hospital, Adelaide, Psychiatric Report, 23 July 2002, (N5, Case 28, pp101-102).
- 288 Clinical Director, Royal Adelaide Hospital, Glenside Campus Mental Health Service, Psychiatric Report, 26 July 2002, (N5, Case 28, p701).
- 289 ACM Woomera, Behaviour Management Plan, August 2002, (N5, Case 28, p61); ACM Woomera Psychologist, Memo, to ACM Woomera Health Services Manager, 5 August 2002, copied to Centre Manager and DIMIA Manager, (N5, Case 28, p62).
- 290 ACM Woomera Psychologist, Memo, to ACM Woomera Health Services Manager, 5 August 2002, copied to Centre Manager and DIMIA Manager, (N5, Case 28, pp63-64).
- 291 Head, Department of Psychological Medicine, Women's and Children's Hospital, Adelaide, Psychiatric Report, 19 August 2002, (N5, Case 28, p150).
- 292 DHS, Social Work Assessment Report on the Circumstances of Children in the Woomera Immigration & Processing Centre, 21 August 2002, pp18-19, (N5, Case 18, pp89-90).
- 293 DHS, Executive Director, Social Justice and Country Division, Letter, to DIMIA Acting First Assistant Secretary, 29 August 2002, (N5, Case 28, p148).
- 294 DHS, Mental Health Unit, Director, Mental Health Services and Programs, Internal Memorandum, to Executive Director, Social Justice and Country Division, 26 August 2002, (N5, Case 28, pp104-107).
- 295 DHS, FAYS, Acting Supervisor, Woomera/Baxter Response Team, Memo, to DIMIA Woomera Manager, 9 October 2002, (N5, Case 28, p56); ACM Woomera, Incident Report WMIRPC 730/02, 9 October 2002, (N5, Case 28, pp317-319).
- 296 DHS, FAYS, Acting Supervisor, Woomera/Baxter Response Team, Memo, to DIMIA Woomera Manager, 10 October 2002, (N5, Case 28, p654); DHS, FAYS, Minutes of case conference (DIMIA, FAYS, ACM, doctor from Woomera Hospital) regarding family, 11 October 2002, (N5, Case 28, p46).
- 297 DHS, FAYS, Minutes of case conference (DIMIA, FAYS, ACM, doctor from Woomera Hospital) regarding family, 11 October 2002, (N5, Case 28, p47).
- 298 DHS, FAYS, Minutes of case conference (DIMIA, FAYS, ACM, doctor from Woomera Hospital) regarding family, 11 October 2002, (N5, Case 28, p48).
- 299 DIMIA Woomera Manager, Facsimile, to DIMIA, Assistant Secretary, Unauthorised Arrivals and Detention Services, 14 October 2002, (N5, Case 28, p154).
- 300 ACM Woomera Mental Health Team, Memo, to DIMIA Woomera Manager, 16 October 2002, (N5, Case 28, pp449-450).
- 301 DIMIA, Unaccompanied Minors and Children Teleconference, 17 October 2002. DIMIA, Letter to Inquiry, 27 November 2002, Attachment B.
- 302 ACM Woomera Psychologist, Urgent Report, to DIMIA Woomera Manager, ACM Health Services Manager and ACM Centre Manager, 21 October 2002, (N5, Case 28, p448).
- 303 ACM Acting General Manager, Detention Services, Letter, to DIMIA Assistant Secretary, Unauthorised Arrivals and Detention Services, 5 November 2002, (N5, Case 28, p429).
- 304 ACM Woomera Psychologist, Letter, to DHS, FAYS, Director, 8 November 2002.
- 305 CAMHS Country Service, A/Regional Director, Letter, to ACM Baxter Health Services Manager, 9 January 2003. ACM, Response to Draft Report, 1 October 2003, Attachment 11.
- 306 Head, Department of Psychological Medicine, Women's and Children's Hospital, Adelaide, Psychiatric Report, provided to CAMHS Country Service, 13 February 2003. ACM, Response to Draft Report, 1 October 2003, Attachment 13.
- 307 Head, Department of Psychological Medicine, Women's and Children's Hospital, Adelaide, Psychiatric Report, provided to DHS, 21 May 2003. ACM, Response to Draft Report, 1 October 2003, Attachment 15.
- 308 Department, Email to Inquiry, 23 September 2003.

A last resort?

- 309 Child and Family Psychiatrists, Psychiatric Report, 12 February 2002, (N5, Case 22, p75).
- 310 Child and Family Psychiatrists, Psychiatric Report, 12 February 2002, (N5, Case 22, p76).
- 311 Medical Practitioner Woomera Hospital, Letter, to DIMIA Woomera Manager, 13 May 2002, (N5, Case 22, p64).
- 312 ACM Woomera Psychologist, Memo, to DIMIA Woomera Manager, 16 May 2002, (N5, Case 22, p66).
- 313 CAMHS Country Service, Women's and Children's Hospital Adelaide, Child Adolescent Mental Health Assessment and Recommendations, provided to DIMIA Woomera Manager, 22 May 2002, (N5, Case 22, p56).
- 314 CAMHS Country Service, Women's and Children's Hospital Adelaide, Child Adolescent Mental Health Assessment and Recommendations, provided to DIMIA Woomera Manager, 22 May 2002, (N5, Case 22, p60).
- 315 DIMIA Woomera Deputy Manager, Fax, to Medical Practitioner, 24 May 2002, (N5, Case 22, 61).
- 316 DIMIA, Response to Draft Report, 4 July 2003.
- 317 DIMIA, Minute to DIMIA First Assistant Secretary, 2 July 2002, (N5, Case 22, p52).
- 318 Child and Family Psychiatrist, Department of Psychological Medicine, Women's and Children's Hospital Adelaide, Psychiatric Report, 3 July 2002, (N3, F13).
- 319 Child and Family Psychiatrist, Department of Psychological Medicine, Women's and Children's Hospital Adelaide, Psychiatric Report, 3 July 2002, (N3, F13).
- 320 DIMIA Woomera Deputy Manager, Email, to DIMIA Central Office, 11 July 2002, (N5, Case 22, p42).
- 321 Paediatrician, Port Augusta Hospital, Medical Report, 2 August 2002, (N5, Case 22, p51).
- 322 ACM Woomera Medical Practitioner, Referral, 13 October 2002, (N5, Case 22, p1).
- 323 ACM Woomera Psychologist, Letter, to DHS, FAYS, Director, 8 November 2002.
- 324 Department, Email to Inquiry, 23 September 2003.
- 325 ACM Woomera, Incident Report WMIRPC 319/02, 11 April 2002, (N3, F9).
- 326 ACM Woomera, Incident Report WMIRPC 319/02, Follow Up Incident Report No.1, 14 April 2002, (N3, F9).
- 327 ACM Woomera, Medical Records, 12 April 2002, (N3, F9).
- 328 ACM Woomera, Interim Risk Treatment Plan, 12 April 2002, (N3, F9).
- 329 ACM Woomera, Incident Report WMIRPC 319/02, Follow Up Incident Report No.1, 14 April 2002, (N3, F9).
- 330 ACM Woomera, Incident Report WMIRPC 319/02, Follow Up Incident Report No.1, 14 April 2002, (N3, F9).
- 331 ACM Woomera, Incident Report WMIRPC 319/02, Follow Up Incident Report No.2, 20 April 2002, (N3, F9).
- 332 ACM Woomera, Incident Report WMIRPC 319/02, Follow Up Incident Report No.2, 20 April 2002, (N3, F9).
- 333 ACM Woomera, Incident Report WMIRPC 319/02, Follow Up Incident Report No.2, 20 April 2002, (N3, F9).
- 334 ACM Woomera, Medical Records, 8 May 2002, (N3, F9).
- 335 ACM Woomera, Medical Records, 17 May 2002, (N3, F9).
- 336 ACM Woomera, HRAT Watch Log, 22 May 2002, (N3, F9).
- 337 Senior Child Psychiatrist, Department of Psychological Medicine, Women's & Children's Hospital, Adelaide, Psychiatric Report, 30 May 2002, (N3, F9). See further, section 9.4.2(c), Example Three and section 9.5.4 above.
- 338 ACM Woomera, HRAT Watch Log, 31 May 2001, (N3, F9).
- 339 ACM Woomera, Medical Records, 7 June 2002, (N3, F9).
- 340 ACM Woomera, Medical Records, 8 June 2002, (N3, F9).
- 341 ACM Woomera, HRAT Watch Log, 14 June 2002, (N3, F9).
- 342 ACM Woomera, HRAT Watch Log, 24 June 2002, (N3, F9).
- 343 ACM Woomera, Medical Records, 30 June 2002, (N3, F9); ACM Woomera, Incident Report WMIRPC 476/2002, 30 June 2002, (N3, F13).
- 344 ACM Woomera, Medical Records, 8 July 2002, (N3, F9).
- 345 ACM Woomera, Medical Records, 13 July 2002, (N3, F9).
- 346 ACM Woomera, Medical Incident Report, 26 July 2002, (N3, F9).
- 347 ACM Woomera, HRAT Watch Log, 29 July 2002, (N3, F9).
- 348 DHS, Social Work Assessment Report on the Circumstances of Children in the Woomera Immigration & Processing Centre, 21 August 2002, p17, (N5, Case 18, p88).