PROFESSIONAL ALLIANCE FOR THE HEALTH OF ASYLUM SEEKERS AND THEIR CHILDREN

Submission

to the

Human Rights and Equal Opportunity Commission

Inquiry into Children in Immigration Detention

May 2002

The Royal Australasian College *of* Physicians

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

CPMC Committee of Presidents of Medical Colleges

AMA

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This submission is available on the RACP website: www.racp.edu.au.

DISCLAIMER

Professionals and asylum seekers provided the case studies in this submission through written statements and clinical notes. Asylum seekers who provided information contained in this submission have given their express permission for the information to be included. The information is accurate to the knowledge of the Alliance, at the date the information was collected.

EXECUTIVE SUMMARY

Introduction

The Professional Alliance for the Health of Asylum Seekers & their Children (Alliance) consists of organisations representing professionals working in the health field, including all medical colleges in Australia. This submission is based on the best available evidence on the impact on children of Australia's current mandatory detention policy for asylum seekers.

Australia's current policy in relation to asylum seekers requires that children arriving in Australia without due documentation (either accompanied or unaccompanied) be placed and kept in detention centres. Experts have advised the Alliance that the outcomes of this policy contravene Australian law and breach our obligations under the United Nations Convention of the Rights of the Child, which Australia ratified in 1990, and other international human rights treaties to which Australia is a party. There can be little argument that the policy also offends traditional and long established Australian standards of humanity, compassion and morality.

Australia is now the only western nation that places all informal and undocumented asylum seekers in mandatory detention for unlimited periods of time. By contrast, Canada, most countries in western Europe and some in central Europe initially place asylum seekers in detention or processing centres for a limited amount of time ranging from 48 hours to 3 months. Unless there are concerns for national security, asylum seekers are then released to reception centres and are free to move in and out of those centres.

Although the Alliance is conscious of the practical impediments to immediate policy change in Australia, it notes that large numbers of Australians, including many leaders of thought and opinion, have condemned mandatory detention, and called for its removal, or for substantial changes, especially as regards children.

Health and welfare issues of children in detention

The first years of life are absolutely vital to the development of children, particularly in relation to their linguistic, cognitive, emotional and social skills. Experiences during the early years of life directly influence the way the brain develops, and can have a substantial impact on the individual in later life.

Research suggests that asylum seekers and refugees (including children) suffer from psychological and physical symptoms sufficiently serious to warrant thorough and routine physical and psychological assessment. Some asylum seekers present with physical sequelae of torture or other violent trauma for which they have mostly not received adequate medical attention in their countries of origin.

Current practices of detention of infants and children are having immediate, and are likely to have longer-term, effects on their development and their psychological and emotional health. Children in these situations are exposed to multiple stressors including:

- behavioural and psychological distress in adults,
- dislocation from protective social groups and structures,
- witnessing violence and self-harm, and
- separation from attachment figures.

These stressors, in combination with prior exposure to conflict and community breakdown, immediately place these children at risk for the development of Post-Traumatic Stress Disorder (PTSD) and its longer-term consequences. In young children, disruptions of attachment relationships, such as removal from a primary carer or multiple changes of carer, are severe stressors and may produce immediate symptoms of distress and behavioural disturbance.

Maintenance of attachment relationships and enabling adults to support traumatised children have been found to protect children from development of chronic PTSD. Children currently held in detention centres have been exposed to the serious psychological distress suffered by adults and by adult self-harming behaviours, and have experienced cultural dislocation and personal and community trauma. It is likely that many will develop chronic PTSD with effects on development. Any additional loss of adult support and attachment disruption is likely to increase symptom severity and contribute to ongoing psychopathology.

The length of time in an institution and the quality of institutional care have major impacts on the potential for the long term recovery of children. The longer the length of time in institutional care, the less likely children are to recover from trauma. The fact that children are likely to be kept in detention for long periods of time if their parents' application for refugee status is rejected at any of the primary stages, and an appeal is lodged, adds to their major health risks.

Health and welfare concerns

The Alliance is concerned that the health needs of asylum seekers and their children are not being adequately met in detention centres. The evidence strongly suggests that the living conditions for asylum seekers and their children in detention centres are not appropriate, and are leading to significant physical and mental health problems. Concerns include the absence of:

- specialist child mental health services needs, such as assessment for mental health problems and for risk of self-harm and suicide; and
- medical and public health services.

The education needs of children in detention centres are also not being adequately met. Each detention centre provides different levels and quality of educational services to children. None of the services provided would be acceptable if given to other children in Australia. Reasonable recreational opportunities are often absent.

In relation to duty of care, health professionals working with asylum seekers in detention centres have several concerns. Firstly, managers of centres often do not act upon the advice of health professionals regarding the treatment required by detainees (whether children or adults). Secondly, health professionals are often unable to speak freely about concerns relating to the health care of detainees, due to contractual arrangements that the professionals are required to sign with detention centres which purport to prevent them from voicing concerns outside the centres to colleagues or health authorities who could help in addressing the situations revealed.

In the long term, placing asylum seekers in the community and providing a welfare benefit may also be more cost-efficient than placing them in detention by saving as much as $70 million per year.

Asylum seekers deemed to warrant refugee protection who are then released into the community with Temporary Protection Visas (TPVs) are not entitled to many of the settlement services provided to refugees who enter Australia with authorisation. Moreover, they are unable to apply to be reunited with even their immediate family, an obvious additional stressor.

Asylum seekers arriving with a valid visa who do not apply for asylum within 45 days of their arrival in Australia do not receive Medicare cover or work rights. Consequently, children of many community-based asylum seekers are at high risk of being socially and economically disadvantaged in all facets of life. Children are often denied basic human rights, including access to health care, because of the visa status of their parents.

Implications for the children and the community

It is difficult for parents/carers to meet the developmental and emotional needs of children within the current system of detention, especially if they themselves have been

traumatised and suffer from a range of mental health problems including depression and anxiety. There is clear evidence that long term health and development outcomes are related to the circumstances that children are exposed to early in life. In relation to children of asylum seekers, rather than receiving the extra care and support they need after experiencing traumatic events, their mandatory detention increases the risk for future short and long term adverse outcomes.

Research also demonstrates that early intervention for children with multiple degrees of risk can have a significant positive impact on children, in particular their long term health, development and social outcomes. This fact has implications not only for the individual, but also for the community at large, in particular in regard to crime, special education and employment costs in the future.

It is of concern that in Australia we are perpetuating the risk for asylum seeking children and families through conditions in detention centres, and adding to the already considerable burden of social and health problems that the community will need to address in the future.

Summary of conclusions and recommendations

1. Based on consideration of the evidence amassed by the Alliance, it is clear that children should not be held in anything other than minimal detention for processing purposes only.

2. As to those presently in detention:

    - all children and their families should be removed from detention and placed in the community with access to all necessary services including health, welfare, education for children and language skills for carers;

    - there should be an immediate clinical review of the physical and mental health status of asylum seekers in detention (Clinical Review) undertaken by independent health professionals (under the auspices of the Committee of Presidents of Medical Colleges) to gain a better understanding of the health status and needs of those asylum seekers;

    - the companies managing detention centres should cease requiring health professionals/staff to sign confidentiality agreements, and cancel such clauses in existing contracts; and

    - a National Summit on Asylum Seekers should be convened (under the auspices of an independent organisation such as this Alliance or a consortium of its constituents). The major task of the National Summit will be to call for submissions about Australia's policies in relation to undocumented asylum seekers (including detention and community-based issues), examine the results of the Clinical Review, examine barriers to good policy (eg jurisdictional and

workforce/remuneration issues relating to child protection, health services etc) and establish a working party to propose reforms to policy in this area.

3. Asylum seekers who enter Australia without travel documents in future should be placed in processing centres for a limited number of days. Those who are not deemed to be a security risk should then be released into the community. Being released into the community can include being housed in reasonable communal accommodation provided it is situated in centres of population.

4. In the longer term:

   - Policy makers and government should work in partnership with the key stakeholders involved in this issue to determine the best ways forward and to develop feasible solutions. This group includes non-government organisations representing refugees and asylum seekers, human rights organisations, academics, lawyers and health professionals.

   - Asylum seekers who enter Australia without travel documents and are recognised as refugees should be granted permanent protection visas. Australia's current policy of granting Temporary Protection Visas is a major barrier to re-settlement in the community.

   - Families should not be separated over long periods of time (for example, keeping one member of the family in detention whilst the child and primary carer are released).

   - Australia should adopt a model along the lines developed by the Refugee Council of Australia, which provides a legislative and regulatory framework for a more flexible detention regime similar to models currently used in Europe and Canada. Under these models, restrictions on the liberty of asylum seekers should be kept to a minimum. After an initial short period in closed detention, all persons other than clear security risks would pass on to a more liberal regime. Regular review of each applicant's detention status would then occur so as to improve the ability to relate the applicant's circumstances more equitably to the restrictions imposed on his/her liberty. Finally, a review process would take place to establish a higher level of equity in the case management of each applicant.

   - Temporary Protection Visa holders should be accorded the same treatment as other refugees in Australia, including access to Medicare, public housing assistance, employment services, education rights for children, interpreter services, language classes, Migrant Resource Centre support, and the right to seek reunification with other family members.

   - A Detention Centre Clinical Review Team (Review Team) consisting of appropriate disciplines should be convened under the auspices of the Committee of Presidents of Medical Colleges (CPMC). The Review Team would visit all

places of detention located both in Australia and off-shore, with a view to examining the standards of care such as human rights provisions, health care (including physical, mental and oral health services), and legal services. Where conditions are considered inadequate or inappropriate, the Review Team will make recommendations for improvement within a feasible time frame (including a follow-up and review strategy). The Review Team should be publicly funded, but be otherwise independent of government.

- Detention centres should provide suitable health facilities with appropriate equipment and trained staff, or arrange for such services to be made available, for the continuing treatment and care of all detainees.

1. INTRODUCTION

1.1 Professional Alliance for the Health of Asylum Seekers & their Children

The Professional Alliance for the Health of Asylum Seekers & their Children (Alliance) consists of organisations representing professionals working in the health field.

The Chair of the Alliance is Justice Marcus Einfeld. Organisations include:

Australasian Faculty of Public Health Medicine (RACP)
Australian Medical Association (AMA)
Australasian Society for Traumatic Stress Studies
Australian & New Zealand College of Mental Health Nurses
Australian Nursing Federation
Australian Psychological Society
Australian Society for HIV Medicine
Brisbane Refugee Health Network
Chapter of Community Child Health (RACP)
Centre for Community Child Health, Royal Children's Hospital (Victoria)
Committee of Presidents of Medical Colleges incorporating:
- Australian & NZ College of Anaesthetists (ANZCA)
- Australasian College of Dermatologists (ACD)
- Australasian College for Emergency Medicine (ACEM)
- Royal Australian College of General Practitioners (RACGP)
- Royal Australian College of Medical Administrators (RACMA)
- Royal Australian & NZ College of Obstetricians & Gynaecologists (RANZCOG)
- Royal Australian College of Ophthalmologists Inc (RACO)
- Royal College of Pathologists of Australasia (RCPA)
- Royal Australian & NZ College of Psychiatrists (RANZCP)
- The Royal Australasian College of Physicians (RACP)
- The Royal Australian & NZ College of Radiologists (RANZCR)
- Royal Australasian College of Surgeons (RACS)

Doctors Reform Society
Medical Association for the Prevention of War
Psychiatry Research and Teaching Unit, School of Psychiatry, University of NSW Public Health Association of Australia Inc
Queensland Nurses Union
Royal Australian & NZ College of Psychiatrists (RANZCP)
The Royal Australasian College of Physicians (RACP)

1.2 Evidence-based medicine framework

This submission is based on the best available evidence on the impact on children of Australia's current mandatory detention policy for asylum seekers.

Evidence-based medicine has been strongly endorsed by the Australian National Health & Medical Research Council[1] (NHMRC), and has been a useful concept in health policy relating to clinical practice.

The Alliance supports the principles of evidence-based healthcare more broadly, and acknowledges the absence of high-quality (according to the principles of evidence-based medicine) evidence in policy making. Gray[2] suggests that:

> "The absence of excellent evidence does not make evidence-based decision making impossible; in this situation, what is required is the best evidence available, not the best evidence possible."

He then proposes various levels of evidence that can be considered in the policy-making process (Table 1), which reflect those endorsed by the NHMRC[1].

In this submission the Alliance has included various types of evidence, as they are all a valuable contribution to our understanding of the impact of detention on children of asylum seekers.

Type	Strength of evidence
I	Strong evidence from at least one systematic review of multiple well-designed randomised controlled trials
II	Strong evidence from at least one properly designed randomised controlled trial of appropriate size
III	Evidence from well-designed trials without randomisation, single group pre-post, cohort, time series or matched case-control studies
IV	Evidence from well-designed non-experimental studies from more than one centre or research group
V	Opinions of respected authorities, based on clinical evidence, descriptive studies or reports of expert committees

Table 1: Levels of evidence that may be used in evidence-based decision making

1.3 Children's rights

Australia ratified the United Nations' Convention of the Rights of the Child[3] (Convention) in 1990.

Australia's current policy in relation to asylum seekers places and keeps children (either accompanied or unaccompanied) in detention centres. The outcomes of this policy result in breaches to Australia's obligations under the Convention as follows:

- Article 3(3): "States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety,

health, in the number and suitability of their staff, as well as competent supervision."

- Article 6(2): "States Parties shall ensure to the maximum extent possible the survival and development of the child."

- Article 9(1): "States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents, or one where the parents are living separately and a decision must be made as to the child's place of residence."

- Article 9(3): "States Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests."

- Article 13(1): "The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice."

- Article 19(1): "States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child."

- Article 22(1): "States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties."

- Article 24(1): "States Parties recognize 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."

- Article 28(1): "States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development."

- Article 31(1): “States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.”

- Article 37(b): “No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time.”

- Article 37(c): “Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances.”

- Article 37(d): “Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.”

- Article 39: “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.”

1.4 Developmental needs of children

There is no doubt that meeting children’s developmental and emotional needs is an issue of great importance. There is also no doubt that by failing to do so, children are at significant risk of a number of adverse health, cognitive, emotional, social and behavioural outcomes that may affect them and their communities well into the future.

In outlining the developmental needs of children, a review of the research demonstrates that there is ample evidence that meeting children’s developmental and emotional needs should be a priority. Although these issues are relevant for all children, of essential importance for present purposes is that they are of particular and worrying relevance for children living in detention.

The developmental needs of children have further been highlighted by the upcoming United Nations Special Session on Children. In the document prepared for this event, 'A World Fit for Children', special attention has been given to the developmental needs of children in recognition of the "recent finding in neuroscience [that] underscore the critical importance of the first moments, months and years in a child's life." This includes not only their basic health and education needs but also, "the enhancement of children's social, emotional, cognitive and spiritual development."[4]

1.4.1 The importance of early childhood experiences

In order to understand how children emerge as adults, and how their interaction with the ecological and environmental systems in which they find themselves can assist or hinder developmental outcomes, it is first important to understand the longitudinal and deterministic relationship that exists between early childhood and all other ages and stages that follow. Children develop within the context of interacting domains such as physiological, cognitive, social and emotional. The developmental trajectory in which children find themselves is a result of the complicated and complex interaction between the genetic makeup of the child and the environment to which they are exposed. Therefore the rate of development is not simply dependent on a maturing process over time, but is a result of the social ecology into which a child is born.[5]

A series of reports released over the last 10 years have undertaken the difficult task of integrating a number of research fields in order to make sense of children's developmental and emotional needs in the context of their long term outcomes. The most recent of these, 'From Neurons to Neighborhoods - The Science of Early Childhood Development'[6] has reinforced our understanding of children's physical, developmental and emotional growth within the context of their family and social environment.

> "Virtually all contemporary researchers agree that the development of children is a highly complex process that is influenced by the interplay of nature and nurture. The influence of nurture consists of the multiple nested contexts in which children are reared, which include their home, extended family, child care settings, community, and society, each of which is embedded in the values, beliefs and practices of a given culture. The influence of nature is deeply affected by these environments and, in turn, shapes how children respond to their experiences."[7]

Several important points should therefore be noted in considering influences on children's development. These include:

- Influences within the child including their genetic makeup, their temperament,[8,9] health[10] and gender[11]

- Influences within the family including family structure, quality of family relationships, levels of conflict,[12,13,14] parent-child relationships,[10,15,16] parenting capacity, style and values[17] as well as contextual factors such as level of parental education, occupation, family income, parental physical and mental health[5,18]

- Influences within the community including the quality and availability of children's services and support for parents and parenting, quality and security of appropriate and adequate housing, neighbourhood safety and crime levels, levels of domestic violence, availability of safe and creative open spaces and places to play, the levels of unemployment and the levels of trust between residents[19,20,21]

- Influences from within the culture a child is born into which cross child, parent and community factors such as parenting styles and beliefs and the level of racism or acceptance within the community[22]

1.4.2 Brain development

Early childhood is thought to hold the key to many future outcomes. Brain research has shown us that this is a time of rapid brain development, during which time many sensory and intellectual pathways are laid down. This presents both a window of opportunity and a window of vulnerability – a time when exposure to appropriate stimuli and experiences in a nurturing environment can protect a child against life's future hardships or can be a time when the devastating effects of neglect and abuse on brain development lead to emotional and behavioural problems that are lifelong.

The process of brain development begins very early in the life of the unborn baby and continues well into adulthood. It is now known that within this developmental pathway, there are times when brain growth is rapid and intensely sensitive to the environment in which a child lives. For instance, in utero the developing foetus is vulnerable to toxins such as drugs and alcohol, as well as maternal stress and malnutrition, all of which can dramatically affect brain development[7]. It is thought that these processes may also affect the growth of the baby and has led researchers to question the role of maternal stress and disadvantage in contributing to low birthweight babies.[23] This has been compounded by research from the UK, which has demonstrated a link between long term disease outcomes, particularly cardiovascular disease and diabetes, and low birth weight.[24] Although the degree of disease and health system costs experienced in the next generation could be significant, there is also the potential for early intervention to avert this future health system crisis by addressing the needs of pregnant women and young families now.

It is also vital to understand that children develop and learn within the context of relationships. When relationships are subverted either through separation, abuse, trauma or depression, the effects on brain development can be significant. It is during these periods of vulnerability, when brain development is rapid, that the impact of environmental trauma can be particularly harmful. Studies by Perry have demonstrated the devastating effect of stress and trauma in the developing brain. His work with children who have suffered chronic abuse and neglect has demonstrated that continuous high levels of stress appear to alter the brain's structure and function in a way that may contribute to poor long term cognitive, behavioural and emotional outcomes and is thought to explain long term behavioural patterns that are maladaptive, require ongoing

therapy and management, and contribute to further long term social and emotional problems for these children.[23]

1.4.3 The environmental context for children's development

The African saying that has been popularised by Hillary Clinton is that "it takes an entire village to raise a child." Although this idiom may not have the same meaning in non-tribal cultures, research has demonstrated the powerful role that communities and neighbourhoods can have on child development. Bronfenbrenner's ecological model of child development[5] portrays nested layers of influence on children that begins with the family who are more immediate, but then moves out into the neighbourhood, the community and the greater social and economic environment. The benefit of this system's approach to child development lies in its power to explain the potential impact of families and communities on the health, development and well-being of children, dispelling any theories that might assume that children's outcomes are a result of any one interaction at any one time.[25]

1.4.4 Children and parents

Whilst the brain development research tells us that learning occurs within the context of relationships, it is also clear that the attachments children have with their primary caregiver is essential to future emotional as well as cognitive outcomes.[23] Research exploring the effects of maternal depression and poor maternal mental health on children range from a distorted view of their child's health[26,27] (which may heighten pre-existing anxiety and lead to increased and unnecessary use of health services) to significant development and emotional problems.[23,28,29]

Parental behaviours and parenting have been related to a broad range of outcomes including children's health (physical and mental),[30] cognitive and emotional outcomes, and even later delinquency and crime activities.[31] Therefore, when the parent-child relationship is disrupted, processes necessary for normal development are also disrupted and the potential for adverse outcomes is significantly increased.[32]

The importance of the nurturing relationship between the child and the parent has been highlighted through the one of final conclusions to the American government of the Institute of Medicine's report "From Neurons to Neighbourhoods" which states:

> "Children's early development depends on the health and well-being of their parents. Yet the daily experiences of a significant number of young children are burdened by untreated mental health problems in their families, recurrent exposure to family violence, and the psychological fallout from living in a highly demoralised and violent neighbourhood."[25]

1.4.5 Children and community

Evidence of the impact of neighbourhoods on children's development, like many other areas, is complex, particularly given the differences that lie within neighbourhoods compared to between neighbourhoods. Theories such as social capital and social environments have emphasised the importance of support processes and networks to enhance the greater well-being of a community. In contrast, communities that are socially disorganised and have large numbers of families living in socially isolated circumstances, are more likely to experience high levels of ill health and a range of adverse living conditions such as poor housing, poverty, violence (including domestic violence), and crime.[33,34] For children living in these dangerous environments, where risk factors such as violence are present, moving children from that environment appears to be beneficial and enhances the physical and psychological health of children and reduces violent crimes committed by adolescents.[25,35]

Within the broader context, UNICEF has acknowledged the importance of children developing within an appropriate environment and have defined and proposed the child-friendly city through their Children's Environment Research Group.[36] This is a city where every child is guaranteed specific rights, namely the rights to: (a) influence decisions about their cities, (b) express their opinion, (c) participate in family, community and social life, (d) receive basic services such as health care and education, (e) drink safe water and have access to proper sanitation, (f) be protected from exploitation, violence and abuse, (g) walk safely in the streets on their own, (h) meet friends and play, (i) have green spaces for plants and animals, (j) live in an unpolluted environment, (k) participate in cultural and social events, (l) be an equal citizen of their city with access to every service, regardless of every origin, religion, income, gender or disability. These can be summarised as an environment that both prevents illness and promotes wellbeing for the child. It includes concepts such as children feeling valued and welcome, and acknowledges that children have special needs for, and indeed rights to, safe, secure and healthy living conditions.[25,36]

1.4.6 Children and culture

Cultural differences and influences are particularly relevant to the context of this document. Cultural differences mean much more than speaking another language, and include values and beliefs, ways of child rearing, and rules of non-verbal behaviour.[37,38] It is also important to note that people from the same country may not necessarily have the same culture. Culture is influenced by many things such as religion, level of education, and spiritual outlook, and may also be influenced by rural or urban experiences.[25]

Culture also influences all aspects of human development and is reflected in the childrearing beliefs and practices of parents. 'The effects of culture on child development are pervasive. Culture prescribes how and when babies are fed, as well as where and with whom they sleep. It affects the customary response to an infant's crying

and a toddler's temper tantrums. It sets the rules for discipline and expectations for developmental attainments. It affects what parents worry about and when they begin to become concerned. It influences how illness is treated and disability is perceived. It approves certain arrangements for child care and disapproves others. In short, culture provides a virtual how-to manual for rearing children, and establishes the role expectations for mothers, fathers, grandparents, older siblings, extended family members, and friends'.[39]

Culture and development are intertwined and interdependent. There is a constant interaction between children and their parents that occurs within the context of their culture which assists children in modifying and adapting to their environment, and as they develop, they will selectively choose from the cultural influences to which they are exposed.[39] The cultural influences in a family's life are often stabilising and reassuring. When there is a mismatch of cultures, often through misunderstanding, the effects on the family can be traumatic and confusing. Within a diverse community such as Australia, there is a need to be ever mindful of the impact of judging people against their culture as "the diverse values that underlie ethnic minorities' approach to family, parenting and community have equal claims to validity, and, in fact, have often existed many centuries longer than the majority Anglo culture."[40]

1.4.7 Education and learning

Education and learning are lifelong activities that begin in early childhood and continue well into adulthood. In fact, children begin learning in infancy and have the opportunity to acquire a great number of skills prior to attending formal education. This is supported by the neurodevelopmental research, which has demonstrated that many of the pathways necessary for learning are well and truly laid down by the time a child begins school.[23] Pre-kindergarten cognitive skills show a strong correlation with achievement in school and early adulthood. Furthermore, evidence from around the world has suggested that children's participation in early and organised high quality learning environments results in improved educational outcomes, including numeracy and literacy, improved self-esteem, better employment prospects, decreased crime, delayed pregnancy and improved health outcomes. Learning and communication skills support the development of critical life-skills including social skills, literacy and numeracy.[25,31,41]

These basic life skills are associated with success in school. Conversely failure to complete school dramatically increases the likelihood of destructive behaviours such as drug abuse, poor employment prospects, low income, welfare dependency, delinquency, violence and crime. It is clear that without attention to problems in speech, hearing and cognitive development, emotional and behavioural problems are more likely to occur. Even educational outcomes in secondary school and beyond can be traced back to academic skills at school entry and relate to the experiences and developmental processes of the child during their preschool years.[25,41]

1.4.8 Risk and protective factors

Risk factors for adverse outcomes often co-occur, and they may have cumulative effects over time. Common indices of family adversity, for example, often cluster together and appear to have long standing effects on children's health and development. Results from longitudinal studies such as the Dunedin Longitudinal Study have contributed to a better understanding of the link between ongoing family adversity and the risk of attention difficulties, poor cognitive performance and delinquency.[42] Family disadvantage has also been linked with greater absenteeism from school due to ill health, and a lower usage of preventative health services such as immunisation.[43] The cumulative effect of familial stressors such as low socioeconomic status, young maternal age at birth, large family size and family instability may therefore have a pervasive effect on the wellbeing of young people.[44]

The numerous factors commonly summarised as family disadvantage or family adversity by these longitudinal studies may have a multiplicative effect on the risk of adverse outcomes in children. Rutter,[45,46] for example, demonstrated that children exposed to six indices of family adversity had 20 times the risk of adverse behavioural or cognitive outcomes compared to children exposed to one or none of the same risk factors. The circumstances imposed on children by a number of interrelated and cumulative risk factors appear to place a particularly heavy burden on them and seem likely to have substantial costs in the long term to both the individual and society.[25] It is important to note, however, that despite the evidence that risk is cumulative, the context of risk remains within the diversity of genetic and environmental risk factors.[29]

Tables 2 and 3 demonstrate the types of factors that have been associated with risk and protection. An ecological approach underlines the relationship between children, their parents and the community. These tables also highlight that resilience in children is a complex interaction between risk and protective factors together with genetic and environmental influences, signifying multiple opportunities to alter children's outcomes, but acknowledging the simultaneous vulnerability that young children have.

When we examine these risk and protective factors it becomes immediately clear that for children living in adverse circumstances, such as children living in detention, the risks related to family and community circumstance are significant. Whilst it is acknowledged that risk is not destiny, there appears no doubt that children and their families living in detention such as currently exists, would require extraordinary powers of resilience to counter such an overwhelming degree of adversity in the face of unmitigated hopelessness and uncertainty.

CHILD CHARACTERISTICS	PARENTS AND THEIR PARENTING STYLE
low birth weight birth injury disability low intelligence chronic illness delayed development difficult temperament poor attachment poor social skills disruptive behaviour impulsivity	single parent young maternal age depression or other mental illness drug and alcohol abuse harsh or inconsistent discipline lack of stimulation of child lack of warmth and affection rejection of child abuse or neglect
FAMILY FACTORS AND LIFE EVENTS	**COMMUNITY FACTORS**
family instability, conflict or violence marital disharmony divorce disorganised large family size / rapid successive pregnancies absence of father very low level of parental education	socioeconomic disadvantage housing conditions

Table 2 Risk Factors In Early Childhood Associated With Adverse Outcomes
Source: A Review of the Early Childhood Literature, The Centre for Community Child Health, (for Family and Community Services), February 2000

CHILD CHARACTERISTICS	PARENTS AND THEIR PARENTING STYLE
social skills easy temperament at least average intelligence attachment to family independence good problem solving skills	competent, stable care breast feeding positive attention from parents supportive relationship with other adults religious faith
FAMILY FACTORS AND LIFE EVENTS	**COMMUNITY FACTORS**
family harmony positive relationships with extended family small family size spacing of siblings by more than 2 years	positive social networks (eg. peers, teachers, neighbours) access to positive opportunities (eg. education) participation in community activities eg church

Table 3 Protective Factors In Early Childhood Associated with Prevention of Adverse Outcomes
Source: A Review of the Early Childhood Literature, The Centre for Community Child Health, (for Family and Community Services), February 20

1.5 Health status of asylum seekers

Research suggests that asylum seekers and refugees, especially children, have a range of illnesses which require health and medical treatment. A recent audit[47] of 102 community-based asylum seekers attending a general practice clinic in Sydney concluded that a significant proportion of those asylum seekers required specialist care. Of the 10 children in that sample, six were under the age of five years.[48] The most frequent presenting problems were infectious and respiratory (Table 4). Although no children presented with psychological problems, many were fearful when examined. Few had received adequate health and medical services (Table 5).

Condition	Frequency
Infectious diseases	3 (viral infections)
Blood diseases	1 (anaemia)
Digestive disorder	1 (peptic ulcer)
Musculo-skeletal	1 (fracture)
Neurological	1 (epilepsy)
Respiratory	4 (2 upper and 2 lower respiratory tract infections)
Skin	1 (eczema)
Social	1 (disability care)

Table 4: Presented health problems of community-based asylum seeker children

	Frequency
Prescription	5
Pathology test	1
Imaging	1

Table 5: Investigations and treatment for community-based asylum seeker children

Another study[49] of 40 asylum seekers attending a charitable organisation in Sydney which provides education and support for asylum seekers, suggested that most were suffering from psychological and physical symptoms sufficiently serious to warrant medical assessment. Thirty reported exposure to premigration trauma, 10 had been subjected to torture, 10 reported gastrointestinal disease, nine musculoskeletal complaints, six gynaecological problems and one had an infectious disease (hepatitis).

Smith has described the similarity between the health of asylum seekers and that of refugees resettled in Australia from overseas.[50] Their general health problems are complex and compounded by the socioeconomic disadvantage they experience in Australia. Likewise in the United Kingdom, studies have found that many of the diverse and manifold health needs of asylum seekers overlap with those of "deprived or excluded groups, ethnic minorities or new entrants to the country."[51]

International studies assessing the health needs of refugees also found a range of health and medical illnesses. In the United Kingdom, one in six refugees has a physical health problem severe enough to affect their life and two thirds have experienced anxiety or

depression.[52] Not surprisingly, a past history of torture, or the feelings of insecurity experienced by refugees, amplify and extend the duration of the illnesses.[53] In addition, post migration factors such as discrimination, lack of social support, and unemployment have been identified as major contributors to anxiety and depression in refugees.[54] Children, in particular, appear to suffer prolonged psychological distress after resettlement.[55]

Some asylum seekers present with physical sequelae of torture or other violent trauma which may not have received adequate medical attention in their countries of origin. These sequelae include malunited fractures, osteomyelitis, epilepsy or deafness from head injuries, or non-specific musculoskeletal pain or weakness.[56] In rape victims, in addition to the psychological sequelae of rape, there is a risk of HIV or other sexually transmitted diseases.

The incidence of infectious and nutritional diseases varies between refugee groups according to their country of origin.[57] The presence of HIV, hepatitis A and B, tuberculosis and vaccine-preventable diseases is a major public health concern.[58] However, severe parasitic and intestinal infections are also common. *Helicobacter pylori* infection is particularly common in refugees from developing countries or in those who have spent time in refugee camps.[59]

1.6 Impact of detention on children

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. Children in these situations are exposed to multiple stressors including:

- behavioural and psychological distress in adults,
- dislocation from protective social groups and structures,
- witnessing violence and self-harm, and
- separation from attachment figures.

In combination with prior exposure to conflict and community breakdown, these stressors immediately place these children at risk for the development of Post-Traumatic Stress Disorder (PTSD) and its longer-term consequences.

There is a body of scientific literature pointing out that infants and children are vulnerable to the effects of stress and trauma and may develop severe PTSD symptoms.[60,61] These symptoms are common within the first month of trauma and have been found to occur in many situations including child maltreatment,[62] violence exposure[63] and natural disasters. Rates of PTSD in children traumatized by maltreatment are similar to those of children traumatized by war and homicide.

In a study of Cambodian adolescents three years after the demise of the Pol Pot regime, 50% had persistent symptoms of PTSD, depression and anxiety.[64] PTSD may become

chronic, and factors such as lack of supportive adults and attachment figures, inadequate mental health services and ongoing trauma can all contribute to persistent symptoms.[65]

Recent research focuses on the developmental implications of early trauma on neurobiological and psychological development.[66] Childhood trauma has been shown to produce alterations of biological stress systems and adverse effects on brain development.[67] These changes are significant because of their association with ongoing vulnerability to stress, and are risk factors for the development of a range of mental health problems including mood and conduct disorders and substance abuse.

Early trauma, including exposure to adult distress and self-harming behaviours, separation from attachment figures and cultural dislocation, constitute significant stressors for children and are likely to be of a magnitude to effect neurobiological development. Research suggests that these effects are persistent and related to ongoing symptoms. There are no effective interventions available to reverse these changes which points to the importance of prevention of traumatic exposure in vulnerable groups such as infants and children.

Maintenance of attachment relationships and enabling adults to support traumatized children have been found to protect children from development of chronic PTSD.[68] Secure attachment relationships are known to increase children's resilience and capacity to manage stress. Children with secure attachment relationships are less vulnerable to the effects of trauma and are able to use their attachment figures for support in processing and resolving traumatic events. Unresolved traumatic experiences are related to chronic PTSD symptoms and mental health problems.

In young children, disruptions of attachment relationships, such as removal from a primary carer or multiple changes of carer, are severe stressors and may produce immediate symptoms of distress and behavioural disturbance. Responses to loss of an attachment figure have been extensively documented and include stages of separation protest, despair and eventual disengagement or withdrawal.[69] Research in Attachment Theory has supported the original hypotheses that attachment disruption and attachment trauma may effect children's ongoing capacity to form reciprocal emotional relationships and is linked to disruptions in personality development.[70] Children with disorganised attachment relationships, often the result of maltreatment or mental disorder in carers, are at risk of development of conduct and emotional problems.[71]

Children currently held in detention centres have been exposed to serious psychological distress in adults and adult self-harming behaviours, and have experienced cultural dislocation and community trauma. In these circumstances, it is likely that many will develop chronic PTSD with effects on development. Any additional loss of adult support and attachment disruption is likely to increase symptom severity and contribute to ongoing psychopathology.

The length of time in an institution and the quality of institutional care have major impacts on the potential for long term recovery of children.[72] The longer the length of

time in institutional care, the less likely children are to recover from trauma. The quality of institutional care is affected by the institution's management – institutions with well trained, well supported staff whose hours are reasonable, who have reasonable breaks and regular inservice are less likely to create abusive environments for children institutions. Thus the fact that children may be kept in detention for long periods of time if their parents' application for refugee status is rejected at the primary stages, and an appeal is lodged, adds to their major health risks.

The specific concerns arising from the literature regarding children in detention centres are that they are exposed to severe adult distress and traumatic behaviours such as self-harm, and that there are inadequate supports for those who may be experiencing acute and ongoing effects of trauma. There are also few appropriate mental health supports for adult carers to enable them to protect children in distress.

As there is limited research on the direct impact of detention on children, it is useful to examine the evidence about the impact of detention on adults (Tables 6 and 7).

Author	**Study Details & Main Findings**
The Victorian Foundation for Survivors of Torture (Parris Aristotle, personal communication, 16 November 2001)	• File audit of clinical assessments undertaken with 46 Cambodian asylum seekers held within the Villawood and Port Hedland detention centres from late 1993 to mid 1994. • A significant number had been held in detention for over two years. • Detailed psychological interviews indicated that the majority of the Cambodians assessed had histories of trauma or multiple trauma. • Sixty two percent were found to meet diagnostic criteria for posttraumatic stress disorder. • Results from routine administration of the Cambodian Version of the Hopkins Symptom Checklist-25 indicated that all of the Cambodians interviewed had scores above the diagnostic threshold for clinically significant depression and 94% had scores above the threshold for clinically significant anxiety. • The authors concluded that the length of detention was a major contributing factor to the level of symptoms displayed.
Victorian Foundation for Survivors of Torture. The East Timorese: clinical and social assessments of applicants for asylum. In: Silove D, Steel Z, editors. The mental health and well-being of on-shore asylum seekers in Australia. Sydney: University of New South Wales, Psychiatry Research & Teaching Unit, 1998: 23-27.	• Survey undertaken in mid-1995 amongst 17 East Timorese held at the Curtin Detention Centre for one to three months. • All asylum seekers reported a common history of repeated and prolonged exposure to violence against themselves, their family and their local community. • Most reported exposure to one or more traumas including random and unprovoked harassment, physical assaults, being arrested and/or detained as well as being subjected to torture. Harassment, assault, detention and killing of family members were also reported by more than half of the clients. • All 17 East Timorese were found to be suffering from PTSD, 94% were depressed and 65% suffered from severe anxiety. Clinically significant suicide ideation was reported.

Thompson M, McGorry P. Maribyrnong Detention Centre Tamil Survey. In: Silove D, Steel Z, editors. The mental health and well-being of on-shore asylum seekers in Australia. Sydney: University of New South Wales, Psychiatry Research & Teaching Unit, 1998: 27-31. Silove D, Steel Z, McGorry P, et al. Trauma exposure, postmigration stressors, and symptoms of anxiety, depression and posttraumatic stress in Tamil asylum seekers: comparisons with refugees and immigrants. *Acta Psychiatr Scand*, 1998; 97(3): 175-181.	• Survey of 25 detained Tamil asylum seekers held at Maribyrnong Detention Centre, Victoria during 1997 and 1998. • Results compared with a parallel community-based study of Tamil asylum seekers, immigrants and resettled refugees living in New South Wales[73]. • Detained asylum seekers reported extensive trauma histories: 72% were victims of torture; 92% had witnessed the murder of family or friends; and 88% had been threatened with death at some time. • Detained asylum seekers reported exposure to an average of 12.4 (of a possible 16) major trauma categories compared with 4.8 for asylum seeker compatriots residing in the community. • Compared to the community group, the detainees were more depressed, suicidal, and suffered more extreme posttraumatic, panic and physical symptoms. Levels of past trauma exposure did not account entirely for the symptomatic differences across comparison groups, suggesting, albeit indirectly, that the immediate conditions of detention might be contributing to the mental health problems of detainees.
Bracken P, Gorst-Unsworth. The mental state of detained asylum seekers. *Psychiatric Bulletin,* 1991; 15, 657-659.	• A file audit of 10 detained asylum seekers seen by the Medical Foundation for the Care of Victims of Torture in the United Kingdom. • Six of the asylum seekers had documented physical evidence of torture known to immigration officials with no attempt being made to secure their release from detention. • All ten (100%) of the detainees reported depressed mood, appetite loss and multiple somatic complaints. • Suicidal ideation was described by four of the detainees with two having a history of suicide attempts.
Pourgourides C, Sashidharan S, Bracken P. A Second Exile: the Mental Health Implications of Detention of Asylum Seekers in the United Kingdom. Birmingham, England: North Birmingham Mental Health NHS Trust. 1995.	• A qualitative study undertaken amongst 15 asylum seekers detained in the United Kingdom • Majority gave histories of traumatic experiences prior to exile, including systematic torture. • They presented depressive and post-traumatic stress symptoms. • The authors reported profound despair amongst the sample with high rates of suicidal ideation and deliberate self harm including attempted hanging.
Sultan A. Testimony. *Lancet*, 2001: 357, 1426	• 36 detainees held for over 12 months at Villawood Detention Centre. • 33 are experiencing clear evidence of severe depressive illness with the remaining three experiencing mild depressive symptoms. • 22 in receipt of anti-depressant medication, with a further nine refusing to take medication for their depressive symptoms. • Six of the detainees have developed clear psychotic symptoms, as indicated either by admission to acute psychiatric units or on the basis of other psychiatric assessments. • Five of the detainees show strong aggressive impulsive and persistent self-harming behaviours. • Most of these people displayed little if any of these symptoms when first detained at Villawood.

Sultan A, O'Sullivan K. Psychological disturbances in asylum seekers held in long term detention: a participant–observer account. *Medical Journal of Australia*, 2001; 175, 593-596.	• Qualitative study based on observations of participant-observer account of a detainee and a clinical psychologist working at Villawood IDC. • Authors describe a pattern of psychological reactions amongst immigration detainees held for long periods of time where each successive stage was found to be associated with increasing distress and psychopathology. • At the most extreme end of the spectrum of disability is the development of a psychological state characterized by severe depression, despair, hopelessness, paranoia, chronic rage, persecutory delusions, sub-syndromal psychosis, characterological change, stereotypic movements and persistent self-harming behaviour. • Observed that these reactions have a marked secondary impact on their children in detention. • In a sample of 33 asylum seekers detained for over 9 months (average period of detention, 2.1 years) over half (58%) were torture survivors. • All but one of the detained asylum seekers displayed symptoms of psychological distress at some time during their period of detention. • 85% had chronic depressive symptoms and 65% had pronounced ongoing suicidal ideation.

Table 6: Impact of detention - evidence from empirical studies

Human Rights and Equal Opportunity Commission: Those Who've Come Across the Seas: The Report of the Commission's Inquiry Into the Detention of Unauthorised Arrivals. Canberra: Commonwealth of Australia; 1998.	• The Human Rights and Equal Opportunity Commission reported that "mental distress in varying degrees is a common manifestation in detained asylum seekers" (p167), with "a large number of detainees experiencing mental health problems" (p153). • Factors regarded as increasing risk to mental distress included prior experiences of torture or other forms of persecution in the country of origin, the stresses created by the length and conditions of detention, and feelings of anxiety and desperation in those whose refugee claims had been rejected. • The report noted that "suicide attempts by asylum seekers….are not infrequent…with numerous examples of detainees attempting suicide or serious self-harm being cited in.... incident reports" (p154). • HREOC also found "evidence of violence between detainees, within families, as well as between detainees and custodial officers" and concluded that there was "considerable tension created by the regime of control necessary to implement the policy of mandatory detention. The evidence suggests that the indeterminacy of detention makes detention considerably more difficult to endure" (p218).
Human Rights and Equal Opportunity Commission: 1998-99 Review of Immigration Detention Centres. Canberra: Commonwealth of Australia; 1999.	• Concluded that the "balance between security and care is undermined by the contractual arrangements between (Department of Immigration and Multicultural Affairs) and the private contractor. The increasing emphasis on security – multiple musters, night curfews….can be traced to the imbalance in these contractual arrangements" (p12).

Commonwealth Ombudsman: Report of an Own Motion Investigation into The Department of Immigration and Multicultural Affairs' Immigration Detention Centres. Canberra: Commonwealth of Australia, 2001.	• Stated that "evidence taken from credible witnesses about the inappropriate use of force, unnecessary "trashing" of rooms for no apparent reason and the alleged harassment of detainees by some (custodial) staff " (p26). • The report concluded that long term detention is a source of frustration, despondency and depression often resulting in drastic action being taken by the detainees" (p20). • Evidence of self-harm, damage to property, as well as fights and assaults suggested "that there were systematic deficiencies in the management of the detainees."
Joint Standing Committee on Foreign Affairs, Defence & Trade, Human Rights Sub-Committee: A Report on Visits to Immigration Detention Centres. Parliament of the Commonwealth of Australia: Canberra; 2001.	• The report states that "most committee members were shocked by what they saw during their visits to the six centres…the physical impact … the double fences, (the) barbed wire. Inside the centres, the strongest memories some committee members retained was the despair and depression of some of the detainees, their inability to understand why they were being kept in detention in isolated places, in harsh physical conditions with nothing to do" (pp65-66). • The Committee found "…that medical treatment was not always satisfactory, that the educational facilities were limited in most centres and that the range of activities was not adequate for the number of detainees " (p67). • The report also highlighted the negative psychological impact of prolonged detention pointing out that "those who had been at Woomera (detention centre) for three or four weeks, for example, were notably less tense and depressed than those who had been at Curtin or Port Hedland (centres) for a year or more" (p104).

Table 7: Impact of detention - evidence from independent inquiries

1.6.1 Case study A: children in detention

This case study provides a summary of the concerns formulated by Dr Paul Carroll (General Practitioner Registrar, Perth) and Dr Annie Sparrow (Senior Registrar in Paediatrics, Perth) during their time as medical practitioners at the Woomera IRPC in July/August 2001 and January 2002:

> "Of particular concern to us are the specific problems related to children in detention. There are a number of children who have been born in detention and who often appear to be developmentally delayed. They have no grass, no dedicated area, no space to be with other infants, play and interact, and hence no stimulation. Other pressures facing children in detention are: the ongoing exposure to trauma of parents and siblings, witnessing acts of violence between officers and detainees, self-harm, mutilation and attempted hangings. Many of them show signs of significant post-traumatic stress disorder and are clingy, withdrawn, quiet and difficult to engage. Secondary nocturnal enuresis is a common problem in child detainees, for which the only current solution is the provision of nappies.
>
> Children are commonly known to be sleeping with their parents again out of fear and anxiety. There are no counsellors available for children, and the lack of

recreational facilities and absence of routine (especially for older children) compounds their problems. There is nothing for an older child to do all day. Excursions and trips are extremely uncommon despite the multitude of leisure facilities available in the Woomera town (3km away) and at Roxby Downs (90km), such as a swimming pool, grassed sports ovals, cinema, tenpin bowling alley, museum, ice cream parlour etc."

1.6.2 Case study B: 16 year old boy in detention

Statement from Mr Roshanak Vahdani, a mental health nurse, about a 16 year old Afghani boy in 'X'* detention centre with whom he has had regular contact since 26 January 2002:

"I found him extremely distressed and in crisis. He cried continuously, expressing hopelessness about living and repeatedly telling me that he wanted to kill himself. He reported being depressed and agitated like this for weeks. This had been worsening in the past few days. He had thought about self-harm continuously since the Red Cross had told him that they could not help him find his parents. He believed them to be dead and hence saw no point in living. He had classical symptoms of a major depression for example depressed mood, suicidal ideations, sleep and appetite disturbances (he had gone on hunger strike for a few days), and severe agitation and anxiety. He refused to let me tell the authorities as he felt that he would consequently be punished by being put on 'suicide alert'.

He had not seen any health professionals since arrival there, although he said that he had been in his current state for a while.

Eventually he agreed and made a contract with me not to harm himself, and I agreed to ring him daily at a regular time to see how he was. He feels somewhat better since my phone calls, but I believe he is still quite depressed and traumatised. He does not sleep at nights, falling asleep at 6 or 7 am and sleeps a few hours during the day. He tells me that no matter what he does he can't sleep and nights are his worst times. He starts to think of his mother, becoming tearful and agitated. He misses his family terribly and is very worried about them. He does not know if they are still alive, and whether they are in a refugee camp in Iran or Pakistan. He believes his father may be in prison, but no confirmation has been given to him.

This is his background. He arrived about six months ago unaccompanied from Afghanistan. He is of the Hazarah ethnic minority and this ethnic minority have suffered persecution in Afghanistan for years. His father was taken by the Taliban three years ago as a political prisoner, and his family did not know of his whereabouts. The boy's older brother was also involved in war and political activity and went missing, so his mother sent him to Australia to protect him from further persecution, telling him that she and his younger brother would follow. The

* The name of the detention centre has not been included to protect the identity of the boy. It is available to the HREOC on request for the purposes of the Inquiry.

trip to Australia had its own stresses and trauma, and he is suffering as a result of being separated from his family. He also suffers from a speech impediment (stutters), which seems to have started in response to the trauma and stresses he has been exposed to. He finds that particularly distressing as he finds it hard to communicate his needs properly. His only supports are myself and one other person who visits him weekly."

1.6.3 Case study C: boy with diabetes

Statement from 'Source C'[+], a general practitioner who works at 'X'[*] detention centre, about a 10 year old boy with diabetes in the detention centre:

"This boy's diabetes had always been managed by his mother up until their time in detention, and his diabetes had been well controlled. During his time in detention, his mother was not allowed to care for the boy's illness, and consequently his diabetes worsened. When the boy was hospitalised in city 'x', his mother was allowed to manage his illness as she had previously, and his diabetes stabilised rapidly. Apparently this occurred a number of times. This case study demonstrates the disempowering effects of detention on the ability of parents to care for their children, and the very damaging effects that this can have on their general health care and their mental health despite the health care facilities available in the detention centre. Parents are disenfranchised in their role, and feel helpless and guilty about being unable to do anything positive for their children. This creates tension and frustration for parents and erodes the parent-child relationship."

1.6.4 Case study D: 13 year old Iranian boy

Statement from Dr Ranll Gunewardene, Psychiatric Registrar; Dr Janne Gibson, Psychologist; and Dr Nick Kowalenko, Clinical Director, Department of Child & Adolescent Psychiatry at the Lower North Shore Adolescent Service:

"Max is a thirteen year old Iranian boy, the middle child of three. In late 2001 a teacher referred him to the Department of Child and Adolescent Psychiatry in the hospital. His past clinical history was unremarkable.

The presenting complaint is that since early 2000 he reports a lower mood than is usual for him; sleep disturbance including less sleep, regular nightmares, sleep walking; feeling worried and distressed when in closed rooms or when away from his parents; losing his temper and feeling irritable; pessimistic thoughts about the future; less enjoyment and interest in previously enjoyable activities; fear and pre-occupation about being sent back to his home country. For the last twelve months he has had a motor tic. His parents report that he is argumentative, tearful, worried and quick to startle for the last several months.

[+] The name of the source is available to the HREOC on request for the purposes of the Inquiry.
[*] The name of the detention centre has not been included to protect the identity of the boy. It is available to the HREOC on request for the purposes of the Inquiry.

The father said that the family had a harrowing trip to Australia, experiencing severe hunger and thirst and encountering pirates who threatened to kidnap Max's sister.

The family members report that further traumatic experiences were experienced during detention in Australia. Upon arrival in Australia in early 2000, the family was placed in a detention centre in a very small cell. The parents were allowed out for ten to fifteen minutes in the morning and in the afternoon. The father stated that as a political prisoner in his birth country he had been treated more humanely. The father spoke of the impact of the extreme isolation and deprivation on all family members, but especially on the two children. In the detention centre, the parents and children witnessed suicide attempts such as attempted hanging, mutilating behaviour such as self cutting and self burning and extreme distress in other detainees. The family said the detention centre experience was very stressful for all of them. Max became depressed while in detention and there were grave concerns regarding his mental state.

Max's experience in detention is temporally related to the development of most of his problems.

Diagnosis: Primary - Post Traumatic Stress Disorder (PTSD). Secondary - Major Depression and Transient Motor Tic Disorder. We are of the opinion that the stressors accumulated during detention were the major cause of Max's PTSD. The course of his post traumatic symptoms was complicated by secondary depression and motor problems.

Our child psychiatric treatment plan included the prescription of psychotropic medication, psychosocial interventions and family psycho-education."

2. CHILDREN OF ASYLUM SEEKERS IN DETENTION

2.1 Inappropriate health care in detention centres

The Alliance is concerned that the health needs of asylum seekers and their children are not being adequately met in detention centres because of a general absence of medical and public health services and no specialist child mental health service. There is a particular need for children to be assessed for mental health problems and for risk of self-harm and suicide.

2.1.1 Case study E: medical facilities at Woomera

This case study provides a summary of the concerns formulated by Dr Paul Carroll (General Practitioner Registrar, Perth) and Dr Annie Sparrow (Senior Registrar in Paediatrics, Perth) during their time as medical practitioners at the Woomera IRPC in July/August 2001 and January 2002:

> "Problems with the management of the medical facilities at the Woomera Immigration Reception and Processing Centre (IRPC):
>
> There is a lack of clear aims/objectives/limitations of the medical clinic. It has never been made clear to the medical staff whether the clinic is a basic first-aid post, a GP surgery, or the equivalent of a low-grade inpatient facility. It has been up to each new doctor to decide the extent of medical care that can be safely provided. There continues to be pressure to keep unwell detainees in the clinic overnight, despite there being neither appropriate nursing staff or resuscitation facilities available. The large number of potentially unwell detainees during the recent hunger strike dramatically exposed these weaknesses.
>
> There needs to be agreed and appropriate clinical guidelines for the management of medical problems that are beyond the scope of the clinic to treat. This includes the decision to transfer patients to Woomera Hospital as well as arrangements with named consultants/teams in major specialties in Port Augusta or Adelaide should secondary or tertiary medical care be required.
>
> In particular, the limited current arrangements for the care of patients requiring acute and chronic psychiatric management on both an in-patient and out-patient basis must be improved and strengthened.
>
> The acute and chronic inadequate supply of appropriate interpreters must be urgently addressed. The medical clinic is an intimidating enough environment without the difficulties of language barriers. Currently, there are no female Farsi translators; it is culturally and medically inappropriate to discuss women's health issues with male interpreters. The Telephone Interpreter Service (TIS) is an insufficient and demeaning substitute (it is even more inappropriate to be discussing gynaecological symptoms with a male interpreter on a speakerphone).

Many presenting symptoms have a stress-induced or psychological element to them, and the absence of counsellors and insufficient number of psychologists (only two or three are present in the centre to cater for the needs of all detainees) requires immediate rectification.

We believe it is not possible to safely manage the medical clinic and ensure the optimum health of all detainees without a minimum of two full time medical practitioners (in addition to Dr Lockwood, the Woomera town and hospital doctor).

Similarly, the current nursing staff levels are inadequate to provide a basic standard of medical care for all detainees.

As the medical staff of the clinic are often temporary/agency doctors, there is a need for a senior medical practitioner within ACM to provide advice and support for doctors employed in detention centres.

Most importantly, the medical clinic requires firm and direct leadership from an experienced nurse/administrator to encourage and ensure that clinic staff treat detainees with the respect that would be given to patients in any other health care environment. The "correctional" mentality employed by many of the detention officers has no place in the medical clinic. An authoritative but compassionate clinic manager is required to ensure that value judgments are not allowed to influence patient care.

Health education as part of an education and assimilation programme to be conducted in the compounds rather than in the medical clinic. The opportunities for preventive health strategies and education about Australian medical systems and practices are far greater outside the clinic. This has been attempted but sadly there are insufficient nursing and medical resources for it to continue at present. The addition of a physiotherapist and occupational therapist to design exercise and recreation programmes targeted at specific groups inside the centre would be invaluable."

2.1.2 Case study F: woman who gave birth

This case study was provided by Dr Louise Newman, Psychiatrist, in relation to a 24 year old woman who is currently in detention:

"I had been informed that Ms C had taken only limited food and drink over a 10-day period and that she appeared to be significantly depressed. She was reported to have experienced episodes of agitation and distress with associated anxiety, hyperventilation and tetany. Ms C has been prescribed benzodiazepines and recently commenced taking an anti-depressant.

Interview

Ms C was seen at the detention centre clinic in the presence of Dr X and with an interpreter. She was alert and oriented and comprehended the nature of the interview. She was distressed and tearful. She was in a wheel chair and stated she was too weak to walk. She appeared unwell and emaciated.

History

Ms C complained of abdominal and lower back pain and offensive vaginal discharge. She stated she had a painful left breast and had headaches. She described severe loss of appetite, nausea on taking fluids and had little oral intake over the past 10 days. She states she has lost up to 12kg in weight since her detention.

She described increasing feelings of depression and despair over the past two months. She admitted to suicidal ideation and thoughts of strangling herself. She felt that if not under surveillance she would harm herself. She said she had little reason to love.

She described constant ruminations on her situation, feelings of being an inadequate parent to her 1-month-old daughter and constant anxiety and agitation. She clearly described several episodes of panic with extreme anxiety, hyperventilation, tetany, tachycardia and difficulty breathing. She feels agitated and anxious in an ongoing way and has progressively isolated herself and recently taken to her bed. She has sleep disturbance with initial insomnia and has been prescribed temazepam 20 mg nocte.

The onset of this depression appears to have been in the post-partum period. Ms C described her distressing experience of giving birth to her first child alone and without any interpreter. She developed mastitis and believes she had a uterine infection. She described her anxieties about caring for an infant in detention and fears for her daughter's future.

Ms C became distressed and agitated on discussing her role as a mother and described her current feelings of wanting to avoid her daughter. She appears to become extremely anxious when holding her daughter and has given over her care to the child's father and other detainees. She is torn between her wish to be a good mother and her feelings of inadequacy and hopelessness.

Observations

Signs: dehydrated with coated tongue, smells ketotic. Tremor and agitation.

Mental state: emaciated with drawn and pale face, tearful and distressed. Unable to walk and in wheel chair. Physical examination indicates significant recent weight loss, dehydration and hypotension.

Painful and engorged left breast with signs of inflammation.

Affect is depressed and anxious. No features of psychosis. Normal thought form. Preoccupied with depressive themes and guilt over her role as a mother. Clear suicidal ideation.

Diagnosis

Major Depressive Episode – prominent anxiety and post-partum onset. Dehydration and probable mastitis, uterine infection.

Ms C appears to be suffering from a severe agitated depression with association 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. This 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 daughter.

Recommendations

- Admission to medical facility for rehydration and intravenous antibiotics
- Investigations for possible uterine infection
- Cease benzodiazepines
- Maintain anti-depressants and transfer to psychiatric unit for assessment of depression and appropriate treatment. This should be in a rooming-in facility with her daughter

2.2 Inappropriate living conditions in detention centres

The Alliance is concerned that the living conditions for asylum seekers and their children in detention centres are not appropriate, and are leading to significant health and mental health problems. After visiting the Curtin Detention Centre, Inspector of Custodial Services in Western Australia, Professor Richard Harding, stated that Australia's detention centres are unacceptably over-crowded, pose hygiene and health risks, and have 'disgracefully' inadequate medical and dental services.[74]

Case studies in this submission have been provided by professionals working in health and welfare. The Alliance received a case study by a third party based on the personal account of a detainee. As the Alliance is unable to verify the contents of the case study, it has been included as Appendix 1.

2.2.1 Case study G: living conditions in Woomera

This case study provides a summary of the concerns formulated by Dr Paul Carroll (General Practitioner Registrar, Perth) and Dr Annie Sparrow (Senior Registrar in Paediatrics, Perth) during their time as medical practitioners at the Woomera IRPC in July/August 2001 and January 2002:

> "Living conditions for detainees within the IRPC
>
> Accommodation facilities for detainees remain inadequate and often below the standard of basic human decency. Many families are housed in rooms the size of an average bathroom, with up to 2 bunk beds to a room. There is usually no living area. The cramped and degrading living quarters are without doubt a major cause of physical and psychological morbidity amongst detainees. Public toilet facilities are often unhygienic and are commonly the cause of the spread of disease within the centre. The cramped and degrading living quarters are without doubt a major cause of physical and psychological morbidity amongst detainees. Many of the rooms are separated from others only by a curtain, constituting a lack of basic privacy for both couples and families.
>
> Apart from small areas of shadecloth, most of the communal areas inside the compounds consist of hard rocky earth with no shade. This is particularly so in the Main Compound, although there are some reasonable communal areas in Oscar Compound (but unfortunately there are no children in Oscar Compound to take advantage of this). We cannot recall seeing any trees above shrub height in any of the five compounds.
>
> The lack of any recreational facilities only serves to reinforce a sense of hopelessness and despair amongst detainees. The addition of such items as a proper children's playground, a garden and grassed/astroturf areas for sport and exercise would greatly enhance the well-being of detainees. There is no grass for the infants to learn to crawl or walk on, and there are no outside areas for children to play on. There is no organised sport such as a soccer area, a basketball hoop/half court, a volleyball court, table tennis, pool table, no ability to exercise or to simply take any pleasure being outdoors. The only activity the inmates can engage in is to watch the area outside their compound. There may only be one television for the entire compound in the mess which is completely inadequate for a few hundred detainees, with no separate area for children or adolescents to have their own dedicated space.
>
> The main sport played by detainees is soccer. However, the only area available as a soccer pitch is on hard stony ground and the children only have thongs to wear on their feet. This means that any games often result in graze injuries and abrasions. We note with interest that "…volleyball courts, soccer pitches and basketball hoops are to be installed now that appropriate playing surfaces have been identified and approved…" but we question why this process has taken more than two years

(Advice from the Department of Immigration and Multicultural Affairs regarding enhancements at Woomera IRPC, January 29th 2002)."

2.2.3 Case study H: family Z

Statement from Dr Sarah Mares, a Child & Family Psychiatrist. The interview was conducted with an interpreter:

"This couple with a toddler and a baby repeatedly begged, "Please take our children, find a place for them away from here. He (our son) will change to a savage not a human. Please do something for a family to adopt him until we can care for him again. He doesn't trust in us anymore. He can't play, he won't eat, he can't sleep well." This family had spent about 10 months in detention without a decision about their refugee status.

Mrs Z had her first child overseas in a normal uncomplicated delivery and had breastfed him for 12 months. She was too distressed to tell me about the second child's birth so the story came from her husband. During the interview she was expressionless and almost mute, occasionally tears coursing down her face. She cared for her infant son in a mechanically adequate way with no animation. She appeared helpless in the face of her older son's behaviour.

Her second child was born in a hospital hundreds of kilometres away by caesarean section that she says she did not understand or consent to. This occurred after a period of 4 weeks enforced bed rest, away from her husband and son, under guard in the hospital. Around the due date, a drip was put up and her waters broke. She did not have any contractions. Several days later she thought "nutrients" were being put into the drip, but woke up to find she had had a caesarean. She did not see her baby for some days and was told she could not breast feed him when he was returned to her, "in case the antibiotics got into the milk". No interpreter was provided to explain either the 4 weeks enforced bed rest, the medical interventions that occurred once she had reached term, or the separation from her son after delivery. No medical explanation (eg pre-eclampsia) was given to her for all or part of what occurred.

She was returned to the detention centre one week after delivery and was not able to attend the follow-up appointment with the obstetrician. She had occasional visits to the ACM nurse who gave her panadol and wound dressings but did not help Mrs Z dress or clean her wound. The wound continued to weep for 6 weeks and remains painful. She feels violated and disenfranchised, out of control of her body and her relationship with her children. The 2 years old's behaviour deteriorated during and after his separation from her. The parent's relationship was also clearly under stress.

The toddler was indeed angry and disruptive. He threw any offered toys away and spat at people, he attempted to eat bits of foam that lay on the floor. He repeatedly tried to leave the room and when he succeeded, wandered quite far from the room until returned by a guard. His father said: "You see his behaviour? It is because we are sad and weeping all the time. He has lost his trust in us." He agreed with a comment that their son seemed angry and perhaps they also felt very angry. He said: "We came here hoping to be free but this is worse. There is a big possibility that I will kill myself here. I am a dead man, every day I am dying. I have brought my family to hell."

His wife had an air of despair. She attempted to limit her older son's behaviour but soon gave up. She asked to leave the interview to take him back to the compound. She remained quiet and withdrawn occasionally weeping throughout the interview, initially placing the baby in the pram in the corner of the room, facing the wall. She fed him without eye contact. Her expression was sad and mask-like. The infant (at a developmental stage when most babies interact socially at every opportunity), made no attempt at eye contact and looked profoundly sad. He made little sound or complaint, but later became more animated when direct attempts were made by the interviewer to smile at and talk with him.

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. I asked whether his desire to have the children placed with another family came out of fear that he might hurt his son, and he said, partly this was true, relating an attempt to cut his own and his son's throat when their refugee application was rejected after many months of waiting. He says he was only stopped from hurting himself and his son by other detainees.

Mrs Z said she has not been able to get appropriately sized clothes for the children, except from other detainees. When she requested new clothes for herself she was told: "Why don't you make something out of the curtains." She also reports being told by the person "guarding" her while she was in hospital for 4 weeks before her son's birth: "You are a prisoner, you have no choice about what happens to you."

Conclusions

From their report, while in immigration detention this family has had a number of inadequate or inappropriate medical interventions that they experienced as traumatic, neglectful and humiliating. They have certainly not been provided with interpreters or explanations that make sense of what has occurred. These events can be listed as:

- separation of mother from toddler and husband for weeks prior to delivery, with a significant impact on the toddler's behaviour
- enforced bed rest, contraindicated prior to delivery unless there were clear medical indications
- inadequate explanation of what was occurring
- Apparent induction of labour without good medical reason, certainly no explanation given
- possible breaking of waters, but likely that no syntocinon was set up, given she reports no contractions
- caesarean undertaken without her consent or understanding, possibly due to intrauterine infection, again no explanation given to Mrs Z
- separation from infant for several days after birth leading to great anxiety on her part, again no explanation given, with an impact on her capacity to breastfeed and bond to her child
- inadequate post operative follow up, analgesia and wound care

Consequences include:

- significant impact on her capacity to parent her children and her relationship with her husband
- Mrs Z is profoundly depressed and unable to adequately parent either child;
- Mr Z is similarly depressed and angry
- toddler is regressed in his/ her behaviour, not sleeping or eating well, angry and defiant
- baby is sad and withdrawn, showing some delay in social development and vocalisation

Circumstances and events occurring in their many months in detention undoubtedly contribute to these significant health and mental health problems."

2.2.4 Case study I: general conditions

This case study is a reproduction of an article which appeared in the journal '*Lancet*'[75] in February 2002, based on interviews with ex-detainees and centre staff from Woomera:

> "Woomera is located in Australia's isolated desert heart, where temperatures reach up to 50°C. Independent observers have great difficulty getting inside Woomera. However, information we have gathered during interviews with ex-detainees and centre staff paints a picture of a grim and punitive environment.
>
> Staff and ex-detainees we have interviewed describe the compound as U-shaped. Detainees are assigned to sections according to the stage of processing of their immigration application. People from different sections cannot easily communicate with each other except by shouting. A grassed administration complex sits in the centre of the compound, separated from the asylum seekers' quarters by a double razor-wire fence and outside the perimeter fence, two water cannons are ready for use.

Many families live in portable units. Air conditioning is often broken and sometimes these units house two families separated by only a curtain. Others live in very small rooms or dormitories. Personal belongings, including photographs, are taken from detainees when they arrive. Children don't have enough room to crawl or play inside, and the climate is too extreme for outside play.

According to the staff and ex-detainees we have spoken to, four musters are held every 24 hours, sometimes at night staff shine torches into people's faces to identify them. Detainees are identified by number and have reported feeling dehumanised by this process.

Housing units have no running water, and the toilet block can be up to 500 metres away. Because of the distance, children have been known to wait until they are incontinent. Visiting specialist professionals with limited access have noticed mattresses left drying in the sun. When the camp was set up in November 1999, water for washing and drinking was available only in the toilet blocks. Water ran hot because the pipes were exposed to the sun. People tried to run the water long enough for it to become cool, but were reprimanded for being wasteful. Eventually, detainees were given small tanks for storing drinking water.

Meals in the centre are provided in an area some distance from the accommodation. Food consists largely of rice, vegetables, and meat thought unpalatable by detainees because it is badly cooked. Furthermore, despite official assurances, the Muslim asylum seekers are not convinced that the meat is Halal. Some of the women help with cleaning the kitchen and chopping food. Detainees volunteer but are not allowed to help with the cooking. Because many children do not like the food, parents supplement their diets with crisps and sweets if they can afford them, and some children are reported to have lost weight.

There are few recreational facilities for children. Only one swing was observed for about 50 children, and fights erupt. Families face difficulties getting their children appropriate clothes that fit — they are given what is available or can place orders that can take from 6 to 9 months to be delivered.

Mothers do not get routine maternal and child health support for breastfeeding or weaning. Nor are weaning foods provided that are appropriate for the age of the children. Each week, families are given two litres of cow's milk, which some mothers feed to infants younger than 12 months.

To obtain disposable nappies, detainees have to submit a form to designated staff at certain set times. Because of this difficulty, many mothers make nappies from old sheets or other material. Changing nappies is hindered by the lack of running water. Women also have to complete a form including the date and personal details when they need sanitary towels. They are supplied with ten pads and face possible questioning by a staff member, who is not always a woman, if more are needed.

Health care is provided in an area separated from accommodation by a wire fence. Detainees are discouraged from seeking health care outside working hours, often have to wait in strong sun, and are introduced by number. Medical staff at the centre are not trained in the treatment of disorders that are common in the home countries of detainees, and have no cross-cultural training. Dental care is not provided routinely to the asylum seekers and consists mainly of extractions — restorative care is almost non-existent.

These conditions have had an enormous effect on the emotional and physical wellbeing of detained families. Parents, frustrated and fed up with trying to care for their families in cramped oppressive conditions, as well as bearing the uncertainty of their immigration status, find it very difficult to remain positive. Many children are unhappy, some cry a lot, and others, craving attention, are aggressive, irrational, and disobedient.

One asylum seeker who had experienced both detention and imprisonment in Australia was quite clear — he preferred prison."

2.2.5 Case study J: Malaria on Manus Island

Press release by the Royal Australasian College of Physicians, 18 February 2002

Health specialists call for immediate removal of asylum seekers at risk of malaria on Manus Island.

The Commonwealth Government and the Department of Immigration & Multicultural & Indigenous Affairs (DIMIA) must act immediately to remove all asylum seekers, in particular pregnant women and children, from Manus Island as they are at high risk of contracting malaria, according to key infectious disease and malaria specialists.

The Royal Australasian College of Physicians (RACP) called for the removal of asylum seekers (in particular pregnant women and young children) from Manus Island following recent cases of malaria among asylum seekers detained there, and the fact that chloroquine-resistant falciparum malaria is endemic on the Island in PNG.

Medical specialists have provided advice to the Government that chloroquine-resistant falciparum malaria is endemic on Manus Island following a request from officers of the Commonwealth Department of Health and Ageing, and DIMIA to the Tropical Medicine and International Health Unit, Menzies School of Health Research, Darwin.

"Recent cases of *falciparum* malaria among asylum seekers detained on Manus Island are a major concern," A/Prof Nick Anstey, Head, International Health Program, Menzies School of Health Research said today.

"Asylum seekers and staff of the detention centre on Manus Island with little immunity to malaria are at significant risk of serious illness or death should they become infected," said A/Prof Anstey.

Prof Richard Larkins, President, Royal Australasian College of Physicians, said: "Given the medical evidence about the prevalence of malaria, in particular the chloroquine-resistant strains, on Manus Island, the responsible course of action is to immediately evacuate the detention centre.

"This is the only truly effective way people at risk can be protected, especially pregnant women and children, but also any others with low immunity," he said

Data from Manus Island indicate that a high proportion of the local population are infected with malaria, many of who have chloroquine-resistant *falciparum* malaria.

"Malaria is a dangerous disease which can rapidly lead to severe illness and death, particularly in pregnant women and young children," the President of the RACP Paediatrics & Child Health Division, Dr Jill Sewell, said today.

"Australia's national antibiotic guidelines recommend that pregnant women should not travel to areas with chloroquine-resistant falciparum malaria, and Australia's policy of placing asylum seekers on Manus Island is putting them at high risk.

"In addition, preventative drugs such as doxycycline and mefloquine are unsuitable for prevention for pregnant women and young children.

"The detainees should be moved to a location where malaria and other potentially dangerous diseases are not endemic, in order to protect the health of asylum seekers and staff working in the facility," said Dr Sewell.

Asylum seekers have been temporarily accommodated on Manus Island in Papua New Guinea, as part of the 'Pacific solution'.

2.3 Inappropriate education services for children

The education needs of children in detention centres are not being adequately met. Each detention centre provides different levels and quality of educational services to children. None of the services provided would be acceptable if given to other children in Australia.

2.3.1 Case study K: Woomera

This case study is a reproduction of an article which appeared in the journal '*Lancet*'[75] in February 2002, based on interviews with ex-detainees and centre staff from Woomera:

> "Education is available only for children aged 12 years and younger, several older children receive almost no schooling. Teaching was provided in one portable unit, 4 days per week for 2 hours, by detainees with teaching experience or some English language. In the past week, there has been some improvement, with some children being bussed to local church buildings for 3 hours schooling per day."

2.3.2 Case study L: Woomera

This case study provides a summary of the concerns formulated by Dr Paul Carroll (General Practitioner Registrar, Perth) and Dr Annie Sparrow (Senior Registrar in Paediatrics, Perth) during their time as medical practitioners at the Woomera IRPC in July/August 2001 and January 2002:

> "The education programme is primitive and under-resourced. The children are now able to go to school in the town, although this is frequently suspended if, for example, a CERT is in progress. This is only available to children 12 and under, which unfortunately excludes many children who would also benefit. The only organised teaching within the centre is up to one hour of English classes a day for the rest of the detainees, but there appears to be inadequate resources to run a comprehensive teaching programme. That very few of the detainees are able to speak any English after considerable time in detention reflects the difficulties in this area."

2.4 Health professionals and duty of care

2.4.1 Concerns of professionals working with asylum seekers in detention

Health professionals working with asylum seekers in detention centres also have several concerns about their own positions and vulnerabilities. Firstly, managers of centres often do not act upon their advice about the treatment required by detainees, whether children or adults. Secondly, they are often not able to speak freely about concerns relating to the health care of detainees, due to contractual arrangements that they are required to sign with detention centres, which prevent them from voicing concerns outside the detention centre to colleagues or health authorities who could help in addressing the situation.

Although the health professional's duty of care to a patient takes priority over a signed confidentiality contract with a detention centre, fear of litigation and subsequent exclusion from the centres and the patients prevent many health professionals from taking appropriate action to alleviate or ameliorate the patients' problems.

2.4.2 The duty of care for health professionals

The duty of medical practitioners to treat all patients professionally with respect to their human dignity and privacy applies equally to the care of detainees[76], irrespective of the reason for their detention.[†] Medical practitioners may not deny treatment to any prisoners, or detainees on the basis of their culture, ethnicity, religion, political beliefs, gender, sexual orientation or the nature of their illnesses.

Medical practitioners who attend detainees should always act in the patient's best interest. No appropriate medical care should be withheld. Medical judgments must be based on the needs of their patients and should take priority over non-medical matters.[77] Medical practitioners should not authorise or approve any physical punishment, nor participate in any form of inhumane treatment.

Governments and private companies controlling detention centres also have a duty of care to all detainees. Medical practitioners should not enter into any contract with a colleague or organisation which may diminish the maintenance of their patient's autonomy, or their own, or their colleagues', professional integrity.[78]

Members of the medical profession are often amongst the first to become aware of violations of human rights and therefore have an essential obligation to call attention to such violations. They should certainly ensure that violations are not concealed as a result of fear of reprisals from the responsible authorities and must seek strict observance of civil and human rights when violations are discovered. Individual medical practitioners who call attention to human rights violations should be supported by the medical profession as whole, and by the rest of the community. Effective machinery should be provided by the profession for investigating unethical practices by medical practitioners in the field of human rights.[79]

2.4.3 Case study M: duty of care

Statement by Mr Wayne Lynch, a nurse/counsellor, who worked in Woomera for 7 months including 4 months as registered nurse and 3 months as counsellor. As a counselor, he worked approximately 80 hours per week, but was employed and paid only for 40 hours:

> "As the only counsellor (for staff and up to 1000 detainees), I was not provided with a room in which to work and nor was I provided with an interpreter. On a daily basis I was asked to do self-harm risk assessments and mental health assessments. Given that I had no interpreter, my assessments were often based on limited English. I expressed my concern to management that most assessments were at risk of being seriously flawed. I left Woomera because I was at odds with management/DIMA over a number of unacceptable practices and the inhumane treatment of detainees (I can provide many objective examples of this if necessary).

[†] The majority of information not specifically referenced has as its basis the AMA Position Statement on Health Care of Prisoners and Detainees, 1998.

As detainee advocate, I frequently took my concerns to centre management, but was advised by the manager that the word "advocate" should be removed from my position description. I frequently expressed my concern that the role of counsellor was tokenistic because rarely were my recommendations in relation to detainee mental health acted upon. When they were acted upon, it was usually because I had obtained agreement about my assessment from another professional to illuminate its seriousness. This was the only way of making certain that detainees received appropriate treatment. As counsellor I wrote to DIMA/management no less than twenty times with concerns about particular detainees. On not one occasion did I receive a written response. On not one occasion did I receive a verbal response unless I presented to management/DIMA after they had received my letters. On many occasions I was reprimanded by centre management for speaking with or writing to DIMA.

Examples

A six-year-old boy whose mental and physical health had dramatically deteriorated following witnessing 3 major incidents in the compound. I made several recommendations about the need for relocation and psychiatric assessment. I was advised that under no circumstances was I to consult with anyone outside Woomera except for the ACM psychologist based in Sydney.

A 10-year-old boy was physically abused on two occasions by guards. After no action was taken against the guards by management, I recommended that it was a case of child abuse and should be reported to Family and Youth Services. I was advised by management that if I did this, I would find myself in a lot of trouble.

A 26-year-old detainee was continuously self-harming (slashing, swallowing glass). He had been handcuffed to a bed in a room and required exceptional amounts of IV/IM sedation. Management wanted this to be administered in the compound under nursing observation and would not agree to his release to hospital. Eventually the medical officer agreed with me and we were able to force relocation to hospital for appropriate treatment.

A 60 year old woman with neurological deficits was not transferred to hospital upon advice of medical and nursing staff. Management believed that it was psychosomatic. Eventually this detainee was diagnosed as having had a stroke and was transferred to Villawood.

A fifty-year-old detainee was clinically depressed with serious suicide ideation after the death of his son. A request was made for his relocation for psychological assessment and support. This request was denied and the response was: "We will have to manage him here."

I faced frequent challenges from management/DIMA and guards who argued that presenting physical and mental ill health in detainees was psychosomatic and contrived to achieve an outcome, and that any referral or relocation outside the centre was inappropriate."

2.5 Legal advice and advocacy

A report[80] by Amnesty International outlines the barriers that detainees have in accessing legal assistance. It demonstrates a complete denial of fundamental entitlements under Australian law. These rights are granted to convicted criminals, but not to asylum seekers in detention. The report states:

"Australian policy regulates the rights of asylum-seekers according to the manner of their arrival in the country. Current practice, laws and directives on the right to legal advice are confusing, complex and inconsistent, for example, in that the law excludes some detained asylum-seekers from the right to be told about the right to request such advice, while at the same time some detention centres may provide information about this right.

According to the Government, an asylum-seeker who indicates clearly his or her wish to seek asylum on arrival will be provided with the relevant forms and the assistance of an interpreter. In addition, the Government states that legal assistance will be made available if the new arrival requests to see a lawyer. However, the government openly admits that asylum-seekers who arrive by boat with no or false documentation are not automatically informed of their right to seek asylum[81], nor of the possibility of contacting the UN High Commissioner for Refugees (UNHCR) or independent legal assistance organisations. Indeed, the Government generally allows such organisations access to an asylum-seeker only if that asylum-seeker specifically requests it. It regularly refuses requests by lawyers and other organisations to visit the detention centres to meet new arrivals and advise them of their rights under Australian and international law.

According to the Government, this policy is fully in line with Australia's obligations to provide protection for refugees. While this policy apparently aims to prevent prolonged legal proceedings on unsubstantiated refugee claims, it may also have the effect of impeding an asylum-seeker's right to a fair process in cases where he or she is not aware of requirements under domestic law nor of his right to legal assistance. In practice, this policy requires that detained "boat people" must be aware of their rights in order to be given an opportunity to enjoy them. However, many asylum-seekers have little or no knowledge of their rights under Australian or international law.

Under international human rights standards and domestic Australian law, all asylum-seekers are entitled to legal assistance to pursue asylum applications. However, Australian immigration law and policy in effect restricts this right in a

manner which shows little regard to the requirement, under international human rights treaties, to give proper effect to the rights enshrined in them.

For example, immigration instructions explicitly exclude the requirement that detainees be advised of the right to seek legal advice, from asylum-seekers who arrive by boat without proper travel documents. In addition, section 193(2) of the Migration Act specifically provides that immigration officials are under no obligation to give certain detained asylum-seekers "any opportunity to apply for a visa or [...] access to advice (whether legal or otherwise) in connection with applications for visas." Under this provision, there is also no requirement to advise detained "boat people" about their right to apply for a protection visa. In other words, they may receive legal advice if they request it, but there is no obligation to tell them, and equally no obligation to inform them, of their right to seek protection in Australia. In practice, there are also discrepancies between some detention centres on the availability of information on the right to legal advice. The manner of entry into Australia should not determine whether asylum-seekers are being automatically informed of their right to legal advice or not."

2.6 Cost efficiency of detention

The overall cost to the Australian government of placing asylum seekers in detention is substantial. According to Parliamentary transcripts[82], the 2001 Commonwealth Budget provided $250 million for unauthorised boat arrivals, of which $190 million was allocated to DIMIA. The mid-year budget review provided a further $147 million, of which $17 million was allocated to costs relating to the detention of asylum seekers on Nauru. Additional estimates in February 2002 provided a further $85 million, of which $18.5 million was allocated to costs relating to the detention of asylum seekers on Manus Island.

In 2001, the cost to the Australian Government for each asylum seeker being held in detention was estimated to be approximately $117 per day.[83] This was based on an estimate that DIMIA had given to a Senate Committee in 2001 of $104 per day, plus an additional loading for indirect costs. Assuming there were approximately 3,500 people held in detention centres in Australia in 2001, the total cost at that time was $150 million per year.

It was also estimated that the alternative of having an asylum seeker living in the community in 2001 was $63 per day. This consisted of a living allowance (based on an individual welfare/health benefit of $250 per week or $36 per day) plus the administrative costs associated with managing the case ($27 per day).

These estimates suggest that, in the long term, placing asylum seekers in the community and providing a welfare benefit may be more cost-efficient than placing them in detention by saving as much as $70 million per year.

A report[84] presented by the Conference of Leaders of Religious Institutes (NSW) also concluded that alternative models to detention are considerably cheaper.

3. CHILDREN OF ASYLUM SEEKERS IN THE COMMUNITY

Asylum seekers generally form two distinct groups[85]:

- those who entered Australia with authorisation (eg with visitors or student visas) and are allowed to remain in the community while their applications are processed; and
- those who entered Australia without authorisation (eg on a boat or plane) and confined in detention until they are granted a visa to remain in Australia or they leave the country.

The Migration Act states that persons who arrive in Australia with documents such as a tourist or student visa and then apply for asylum within 45 days of arrival will receive a bridging visa allowing work rights and access to Medicare. However, persons not applying within this specified time are not entitled to these rights. This includes their partner and any children. Such asylum seekers who require medical treatment or care such as antenatal services are forced to pay up-front. In addition, since July 2001 persons without Medicare cover have to pay the full (unsubsidised) price for any prescription medications.

Prior to 1999, if an application for refugee status was successful, the asylum seeker was eligible to receive a permanent protection visa which provided permanent residence, and immediate access to the comprehensive settlement support arrangements available to refugees resettled from overseas.

Since October 1999, asylum seekers arriving without authority are only eligible to receive three-year Temporary Protection Visas (TPV) in the first instance.[86] If their refugee application is approved, they are released from detention and their TPV gives them access to Medicare, work rights, torture and trauma counselling and some social welfare. TPV holders are not entitled to many other settlement services provided to refugees who enter Australia with authorisation, such as English language classes. Furthermore, TPV holders are not able to apply for their families to join them, and cannot leave Australia (eg to visit their families or attend a family funeral) unless they abandon their visas.

Previously, a TPV holder was able to apply for a permanent protection visa after 30 months. Legislation was enacted in 2001 to amend the TPV system to make it more difficult for asylum seekers to obtain permanent protection visas. Unauthorised asylum seekers who entered Australia through a country where they spent more than seven days and could have sought and obtained protection, are not eligible for permanent visas and can only apply for recurrent temporary visas. Undocumented asylum seekers who entered Australia and did not reside in a country where they could have sought and obtained protection, are eligible to apply for a permanent visa after 30 months.

Sections 3.1.1 to 3.1.3 have been copied from the article 'The health needs of asylum seekers living in the community' by Harris and Telfer in the Medical Journal of Australia.[47]

3.1 Health needs of asylum seekers

3.1.1 Access to health care

In Australia, to be eligible for essential medical services through Medicare and the Pharmaceutical Benefits Scheme, asylum seekers with a valid visa must apply for asylum within 45 days of their arrival in Australia. As a result of this "45-day rule" and other government restrictions, about 40% of asylum seekers are denied Medicare and work rights.[87] If they appeal their case to the Refugee Review Tribunal or the courts (as most asylum seekers do who are unsuccessful), these restrictions can persist for many months to years. Asylum seekers experience a greater burden of ill health, lower socioeconomic status and greater problems accessing affordable and appropriate health care.[49,50]

In exceptional circumstances asylum seekers who are denied Medicare and work rights can receive help from the Asylum Seekers Assistance Scheme (ASAS). ASAS is a Commonwealth Government scheme administered by the Red Cross, which provides financial assistance and healthcare to a small proportion of eligible asylum seekers.[88] In 2000-2001, the scheme assisted 2641 ASAS-eligible asylum seekers. However the number of community-based asylum seekers 'unable to meet their most basic needs' exceeds the scope of the scheme. For example, in 2000-2001, the Red Cross assisted an additional 1475 non-ASAS asylum seekers who were officially ineligible for the scheme, but were unable to meet their most basic needs (ASAS, National Office of the Red Cross, Melbourne).

In Australia, there have been few studies of access to healthcare of asylum seekers. In the 1994 study of 40 asylum seekers[49], 27 expressed concerns about not obtaining treatment for general health problems over the previous 12 months, with 25 citing lack of access to Medicare as the main reason; 21 reported poor access to emergency care and 19 to long term medical care; and 27 reported difficulty accessing dental care.

3.1.2 The role of healthcare workers

Healthcare workers have an ethical responsibility to provide life-saving care for asylum seekers in Australia. However, this responsibility is not always clear cut, and clinicians, in their attempts to provide care in a timely way, are often frustrated by State and Commonwealth health department policies. Patients with physical conditions requiring investigations (such as possible malignancy), with subacute conditions (such as extrapulmonary tuberculosis), or with chronic conditions which may result in acute complications (such as diabetes), face significant barriers to accessing health care. Very often they rely on charitable organisations and the ingenuity of volunteer healthcare workers to "bend the system". This is becoming increasingly difficult.

3.1.3 Case study N: 27 year old man with tuberculosis

Statement by 'Source S'[+], a medical doctor.

> "A 27 year old man whose case was before the Refugee Review Tribunal had experienced trauma during imprisonment in his country of origin and had sleep problems as a result.
>
> He had abdominal pain, diarrhoea and fever for 3-4 months. He felt constantly tired and lethargic and had lost 9kg (down to 43kg). He had been unable to get medical attention because he was not eligible for Medicare.
>
> On examination, his right abdomen was very tender and he had an enlarged liver. His haemoglobin level had fallen to 86 g/L (normal range, 120-160 g/L), and he had a lowered white cell count and a raised erythrocyte sedimentation rate of 60 mm/h (normal range 5-15 mm/h). The provisional diagnosis was tuberculosis or malignancy.
>
> He was referred to senior gastroenterologist, who tried to admit him to hospital for further investigation. However, the hospital would not authorise his admission as he did not have a Medicare card. After multiple entreaties by the doctors involved, the Red Cross lodged an application with the department for financial coverage of his health costs in a public hospital. This took 5 days to organize, during which time he suffered repeated blackouts at home.
>
> He was eventually admitted to hospital a week after the original recommended urgent admission date and investigations confirmed a diagnosis of tuberculosis. He was treated with antituberculosis chemotherapy and has made a slow recovery over 6 months."

3.1.4 Case study O: 6 year old boy with hearing loss

This case study was provided by a Coordinator[+] in the Refugee Claimants Support Centre (RCSC) (Brisbane) and a Migration Agent[+] at the South Brisbane Immigration & Community Legal Service:

> "The six year old son of a family of refugee claimants was referred to a hearing test with an audiologist by school teachers, who had become increasingly concerned over the boy's problematic behaviour in class, his learning difficulties and general inattentiveness. According to the parents, their boy had for a long time been sickly and in bad health, had had many falls and little accidents, and was not developing well.

[+] The name of the source is available to the HREOC on request for the purposes of the Inquiry.
[+] The name of the source is available to the HREOC on request for the purposes of the Inquiry.
[+] The name of the source is available to the HREOC on request for the purposes of the Inquiry.

The test found that the boy had considerable hearing loss in both ears and was required to wear hearing aids. Two hearing aids were fitted by the audiologist, and the family was presented with the bill of around $400. The family had been living on a bridging visa without work permission and without a Medicare card for almost two years. They had been surviving on charity, homeless and hungry at times, without access to the Asylum Seekers Assistance Scheme[‡]. This was not known to the school before they arranged the appointment for the hearing test, and the staff at the hearing centre had automatically assumed that the family would have a Medicare card '….as every other school kid has'.

After the RCSC wrote a letter to explain the financial situation and inability to pay of the family, the audiologist decided to not take the child's hearing aids away from him. Instead they changed their procedures — in future children without initial presentation of Medicare card will not be seen.

The little boy is encouraged by the family to do without the hearing aid when he is at home, so the expensive batteries will last longer. Both children of this family do not have access to regular checks, immunisation, or treatment of childhood diseases. If they receive a prescription, eg for antibiotics to treat a middle ear infection, the parents cannot afford the cost. Without a Medicare card PBS medication is not accessible to them.

3.*1.5 Case study P: 6 year old boy with injured shoulder*

This case study was provided by a Coordinator[+] in the Refugee Claimants Support Centre (Brisbane) and a Migration Agent[+] at the South Brisbane Immigration & Community Legal Service:

"A six year old boy from an asylum seeker family of five, who had been waiting for a final decision on their application for protection for over four years, was given a small bicycle as a gift from a community group. He and his brother were full of joy over the generous gift, and immediately took the bicycle to the backyard to practice.

The boy fell and injured his shoulder in the process. He was taken to the hospital, and after a stay over night was released with a shoulder and arm set in plaster. The bill for treatment and hospitalization was several hundred dollars. As the family had no work permission, no Medicare card and lived on charity, they were unable to pay the medical bill. The hospital's debt-collector visited them, and threatened that there would be a legal ending and possible court proceedings over their non-payment.

[‡] A Government scheme administered by the Red Cross which provides financial assistance and healthcare to a small proportion of eligible asylum seekers

[+] The name of the source is available to the HREOC on request for the purposes of the Inquiry.

[+] The name of the source is available to the HREOC on request for the purposes of the Inquiry.

The parents became anxious over what this debt may mean for their case decision by the Minister, and the little boy had feelings of guilt and great worry over their future. He said he would try his best to '…never get sick'.

Note: Hospitals do not refuse treatment of refugee claimants without a Medicare card, but many general practitioners do. Hospitals do, however, pursue the costs of their treatment. Debt collectors automatically follow normal procedure and their threats of legal action leave families deeply traumatized. Community workers advocated in this case to get the fees waived."

3.1.6 Case study Q: father and daughter

This case study was provided by a Coordinator[+] in the Refugee Claimants Support Centre (Brisbane) and a Migration Agent[+] at the South Brisbane Immigration & Community Legal Service:

"After living on a bridging visa for three years the father of a twelve year old girl suffered anxiety attacks, paranoia and deep depression over the trauma of being faced with deportation to his country where he was sure he would be further persecuted, and also over his experiences with the asylum seeking process here in Australia (not being believed, threatened with refoulment, losing work permission & Medicare card). As he was also suicidal, he was forcibly admitted by community workers to the mental health ward of a local hospital.

Interpreters were not readily available or were not used as his young daughter could speak some English, so she was required to help the staff communicate with the father upon admission and on several other occasions. This experience was deeply disturbing to the child. There was also the suggestion that she help translate a letter written by the father to the doctors, which seemed to contain his plans to die should he be sent back.

Upon release from hospital the father locked himself and his family into their accommodation, and did not allow the child to go to school, play, meet other children or talk to anyone. Instead, she had to help him ring and talk to community members, politicians, lawyers and the media in a bid to secure safety. The girl had to find 'the right words' to translate all his requests into English, translate Department documents and legal jargon for the family (only she spoke English - after three years here as parents were barred from English classes as asylum seekers). She was forced to bear witness to the father's and mother's fear, his threats to kill his family and himself, breakdowns, outbursts of anger and self-harm in his attempt to secure a visa.

[+] The name of the source is available to the HREOC on request for the purposes of the Inquiry.
[+] The name of the source is available to the HREOC on request for the purposes of the Inquiry.

Community workers who knew the child well considered her strong and calm in the face of the chaos around her. Nevertheless, she complained of nightmares, sleeplessness, lack of appetite, deep sadness and constant worry that her father might get killed and she would have to take care of her mother. She felt so hopeless."

3.1.7 Case study R: mother and three children

This case study was provided by a Coordinator[+] in the Refugee Claimants Support Centre (Brisbane) and a Migration Agent[+] at the South Brisbane Immigration & Community Legal Service:

"A mother and her three children have been seeking asylum in Australia alone, as their father never made it to the airport. They lived in the community, waiting for many months to hear from him so he could join them in safety (with dwindling hope that this would ever happen).

Both mother and teenage son have gone through great trauma as well as torture at the hands of religious persecutors. As asylum seekers they have no access to trauma counselling, and no interpreter services. The two young siblings are very much affected, but there is not much help for the family. Shelter and food is provided by charitable organisations and the community.

They are not sure whether they will get a protection visa. The children don't leave their mother's side if they can help it, and are very protective. The older son feels that he is responsible for the family's survival now, but it is difficult for a young man who has just finished school in his country, has limited English and no skills to find work. As part of his culture, due to the absence of his father, he is the breadwinner of the family. In Australia he is unable to do his 'duties as a son', and feels even more disempowered and gets exceedingly depressed.

The fourteen and ten year olds had been prevented from going to school for almost a year by government policy before the Refugee Claimants Support Center was able to receive a ministerial exemption for them. Their future is insecure."

3.1.8 Case study S: woman with diabetes

Statement by 'Source S'[+], a medical doctor.

"This case study demonstrates lack of communication between DIMA/ACM staff and medical staff in the detention centres. Detainees with health problems can be released (once deemed refugees) at short notice without adequate follow up arrangements/documentation etc. Medical records rarely are provided, and

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obtaining medical information about detainees after their release is highly problematic.

I saw a young woman from Iran in late 2000. She was an insulin dependent diabetic and had been released from Villawood the previous afternoon without insulin or other materials. She was provided with insulin and the local diabetes clinic gave her enough syringes etc until more could be arranged. DIMA needs to be aware they could be liable for any poor outcome related to this issue."

3.1.9 Case study T: 19 year old woman with HIV

Statement provided by 'Source T'[+], a medical doctor.

"E is a 19 year old single woman who is a refugee from Ghana with no family in Australia. Both her parents are dead. Her refugee status is still pending with DIMIA and she has no Medicare card. She had a history of termination in Ghana after having been assaulted.

She presented at 5 months gestation confirmed on ultrasound. Routine blood tests (which she had not been able to have done previously because of no access to Medicare) including a HIV test were performed. The HIV result was positive (confirmed on Western blot with p24 antigen positive). When the patient was informed she became extremely upset and asked to have the test repeated. She had no knowledge of her HIV status prior to this, nor had she had any AIDS defining illness. The second test again was positive.

It took several weeks to get her treated with antiviral therapy. This was critical in preventing her child from becoming infected with HIV. Finding a hospital where she could be delivered was also difficult and took several weeks to arrange. She has subsequently delivered and fortunately the infant is HIV negative."

3.2 Living conditions for children in the community

Between financial year 1999/2000 and October 2001, approximately 6,811 asylum seekers were granted a TPV.[86] Therefore, it may be estimated that there are currently at least 8,000 community-based asylum seekers in Australia.

As outlined earlier, TPV holders are not entitled to many settlement services provided to refugees who enter Australia with authorisation, and asylum seekers with a valid visa who do not apply for asylum within 45 days of their arrival in Australia do not receive Medicare and work rights. Consequently, children of many community-based asylum seekers are at high risk of being socio-economically disadvantaged in all facets of life. Children are often denied basic human rights because of the visa status of their parents. This raises serious ethical implications for doctors and health workers who consequently

[+] The name of the source is available to the HREOC on request for the purposes of the Inquiry.

face the choice of discriminating on the basis of immigration status by denying basic heath care to those in need.

In relation to TPVs, a report[89] by the Queensland Department of the Premier and Cabinet concluded that:

- they have a negative impact on asylum seekers' physical and psychosocial health, employment prospects, settlement and general well being;
- they are discriminatory and unfair as they create two classes of asylum seekers with different entitlements and thus cause tensions within and between ethnic communities; and
- the loss of refugee places from the offshore program exacerbates tensions as ethnic community members whose relatives and friends face a longer time waiting for their applications to be processed tend to direct their resentments, unfairly, at asylum seekers with TPVs.

The Report also stated:

> "The TPV policy severely limits people's capacity to participate in the every day life and activities of Australian society. In effect, this policy setting will reduce opportunities to become independent, and may well create a long term burden on the government and welfare sectors…In the long term, the policy is likely to create serious social problems as, lacking access to specialist refugee services, TPV entrants are likely to experience poor settlement and disadvantage."

Research studies[90] in Ireland of children of community-based asylum seekers with much more generous welfare, health, schooling, housing and other provisions than in Australia, raised concerns about their system and the way it marginalised this group of children.

The United Nations Convention on The Rights of the Child[3] states that "all children should be entitled to basic rights without discrimination".[91,92] Yet children of community-based asylum seekers in Australia are often exposed to severe and untreated mental illness in their parents. Children who can speak any English often have to translate for their parents, including stressful situations. Sometimes these children have to detail the torture and trauma experiences of their parents for health practitioners and others, and must explain their parents' suicidal feelings. These are highly traumatising events even for adults to relate. For children they are particularly stressful especially as the events concern those who are supposed to be their major protectors in life.

3.3 Education and children in the community

Asylum seekers in the community receive no financial assistance to pay for costs relating to education, such as school fees. Any exemption for payment of school fees must be applied for individually to the relevant state ministers and is not administered systematically or in accordance with children's rights. Often church-based schools approach their governing bodies and accept children of community-based asylum seekers

linked to strong community worker advocates on a charitable basis. Other educational costs such as transport, uniforms, text and exercise books are a further burden for parents and carers of children of asylum seekers.

3.3.1 Case study U: children in Queensland

This case study was provided by Ms Mandy McNulty, a caseworker/community worker at the South Brisbane Immigration and Community Legal Service and the Chairperson of the Refugee Claimants Support Centre (RCSC):

> "The RCSC is a small organisation that provides material and emotional support, emergency accommodation, emergency relief and advocacy for asylum seekers in Queensland. The RCSC receives $50,000pa funding from the Sisters of the Good Shepherd to cover wages of the coordinator(s), rent of premises and operating costs. Additionally the RCSC has had some success in attracting project funding from BCC in particular and also from MAQ.
>
> The education of asylum seeker children is an ongoing vexed issue for the RCSC and its clients. It takes up an inordinate amount of the coordinator's time.
>
> Background
>
> In 2001, Gaby Heuft (RCSC coordinator), Anne Manning (Good Shepherd Sisters) and Barbara Ashby (Amnesty International) had an appointment with the Minister's Parliamentary Secretary. The issues were discussed and there was an agreement that these matters would be investigated and that there would be follow up but so far, there has been no follow up.
>
> The issue
>
> Queensland law states that children must be sent to school and their parents are subject to prosecution if this does not occur.
>
> Children of asylum seekers are classified as overseas students and are thus expected to pay full fees at state schools. Many asylum seeker families are totally without any form of income because the parents do not have permission to work.
>
> Some schools will admit asylum seeker children and absorb the cost but other schools will not. Because of their lack of income, parents cannot pay the transport costs to get children to the schools that will enrol the children. An exemption from payment of fees can be sought on the grounds of financial hardship. The exemption needs to be obtained every term.
>
> As far as I am aware, the information RCSC workers have been given is that such an exemption can only be granted by the Minister for Education and that this power cannot be delegated. It is difficult for asylum seeker families to approach the

Department of Education or the Minister's office due to language barriers and often due to a fear of government authority. The process of obtaining an exemption typically takes several months, during which time the children are excluded from school.

Typically the process of obtaining an exemption involves a huge amount of advocacy and lobbying on behalf of the family concerned. This activity diverts scarce worker time from other pressing issues such as ensuring that asylum seekers are housed and fed and have adequate medical care. Often other workers, such as SBICLS legal workers, also become involved in the process because it is so difficult.

The Queensland Government requires children to attend school but the process of admitting asylum seeker children to state schools is slow (typically 3 – 6 months) and takes a huge amount of worker time to achieve an exemption from fees, which, in the end, is inevitably given.

Recommendation

RCSC suggests that the Queensland Department of Education exempt asylum seeker children from paying overseas student fees at state schools. We suggest state school administrators be given information and guidelines that will enable them to routinely enrol asylum seeker children. We suggest that the process might be as simple as the school administrator sighting the visa held by the applicant as well as a letter from DIMIA, which acknowledges receipt of an application for a Protection Visa (subclass 785 or 866)."

4. IS THIS THE ONLY WAY?

According to Amnesty International[93]:

> "Most Western countries recognise that a process must be in place for all entrants to a country to verify identity and to undertake health and security checks. Yet once these initial procedures have taken place there are alternatives to keeping asylum-seekers in detention while the refugee determination procedure proceeds.
>
> Ongoing arbitrary detention with no recourse to judicial review is a violation of human rights. Asylum seekers have been detained for up to four years and children have been born into detention. There are better more economically viable and more humane ways of responsibly handling onshore asylum-seekers."

Australia is now the only western nation that places all unauthorised asylum seekers in mandatory detention for unlimited periods of time.[94] In order to develop recommendations for Australia's policies in relation to asylum seekers, it is useful to examine the models of other western nations in managing unauthorised arrivals.

4.1 Europe

4.1.1 General

No European state has a mandatory non-reviewable detention policy for unauthorised arrivals.

Most countries in western Europe and some in central Europe initially place asylum seekers in processing centres for a very limited amount of time ranging from 48 hours to 3 months (see Table 8).[95] Unless there are concerns for national security, asylum seekers are then released.

Most European nations have a system of reception centres for asylum seekers. Residency in those centres is not usually compulsory, but is often required in order to access government assistance. Some states impose movement restrictions on asylum seekers within the province/district in which the reception centre is located. Some nations have no assisted accommodation and welfare services.

COUNTRY	REVIEW[§]	BASIS FOR DETENTION[**]
Austria	appeal rights	for illegal entry - limited to 48 hours
Belgium	appeal rights	exceptional circumstances only - linked to national security and public order
Czech Republic	automatic review	initial confinement (max 21 days) then residency requirement
Denmark	automatic review and appeal rights	manifestly unfounded or on security grounds
Finland	automatic review	identity not established or reasonable cause to believe that the person might abscond
France	automatic review	max 20 days: manifestly unfounded claim, threat to national order/security, exclusion under Dublin or Schengen Agreements
Germany	appeal rights	up to 19 days for undocumented airport arrivals or as penalty for breach of residency requirements
Greece	appeal rights	possible detention before lodgement
Italy	automatic review and appeal rights	limited duration (96 hours before review): insufficient documentation, suspected criminal, forged documents
Netherlands	automatic review and appeal rights	prior to lodgement or if application deemed inadmissible or manifestly unfounded
Norway	automatic review	only where there has been a breach of residency or reporting or reporting conditions
Portugal	automatic review and appeal rights	detention rarely used — associated with penal proceedings

[§] Right to appeal to an independent body (court or tribunal) and/or automatic review by a judge after a specified period and/or internal review by the body that made the decision to detain.

[**] This does not include detention of rejected asylum seekers.

Slovakia	internal review	short term detention at airport for undocumented arrivals
Spain	automatic review	max 7 days: until submission of claim
Sweden	internal review and appeal rights	max 6 hours without detention order (for manifestly unfounded claims or identity concerns), then max 2 months (with rare exceptions)
Switzerland	automatic review and appeal rights	max 3 months for specific categories including refusal to reveal identity, violation of restriction of movement order, threat to public order etc
Turkey	appeal rights	only where a person has violated a residency order
United Kingdom	internal review and appeal	specific criteria including failure to comply with conditions and blatant disregard for immigration laws

Table 8: The detention of asylum seekers in Europe[95]

4.1.2 Sweden

Sweden receives similar numbers of asylum seekers as Australia, despite having less than half the population.[94]

In 1997, the Swedish government held an inquiry to examine their detention policy following numerous hunger strikes, suicide attempts and a hostage incident in the detention centres which private companies then managed.[96] As a result of the Inquiry, the management of detention centres was placed within government responsibilities under the Department of Immigration. Since then the incidence of self-harm has fallen and there have been no major incidents of violence.

As outlined in the table above, Sweden has a policy of placing asylum seekers in detention whilst establishing a person's identity and conducting criminal screening.

The Swedish system is summarised below.[97]

Detention

There are three categories of detention for asylum seekers.

Category 1. ID (identification) detention, where asylum seekers may be held in detention for two weeks to two months while their identification is being ascertained.[††]

Category 2. Investigation detention, where the rights of asylum seekers to be released into the community are being investigated. This is generally when there are questionable aspects to their identity and further investigation is needed, particularly if there is a possibility of national security being at risk following release of the asylum seekers. Asylum seekers in this category can be held in detention for two months and extended to a maximum of four months.

Category 3. For asylum seekers who are in all probability to be deported shortly or it suspected that they will go into hiding if released. Asylum seekers in this category can be held for a maximum of two months, usually for the duration of the preparation of travel documents.

Under Swedish law, no child under 18 years can be held in detention for more than three days. In extreme circumstances this can be extended to six days.[‡‡] If an unaccompanied minor arrives in Sweden, the child is taken directly to a supervised group home run by the Immigration Department and Child Social Services. If a family arrives without documentation or if the family is about to be deported, in many cases it is released into family accommodation at the Carlslund Refugee Reception Centre under compliance, reporting daily to the Department.

However, in cases where the threat to national security is unknown, where their identity cannot be ascertained or where authorities are unwilling for their release, the husbands are held in detention while women and children are released into group homes outside of the detention centre. The women and children are able to visit their husbands and fathers during the day. Group homes are normally supervised with access to information, legal advice, counselling and recreation. All who live in the homes are involved in food preparation. There are also regular group meetings with consensus deciding all issues. Telephone translators are available whenever required.

All detainees are aware of their rights in detention and the length of time they can be held in detention. All detainees have a right under Swedish law to appeal against their detention. Asylum seekers are kept in detention only for the period of time it takes to ascertain their identities, not for the duration of their asylum procedure. On average this takes between two weeks to two months.

Carlslund Detention Centre

There are no barbed wire fences surrounding the detention centre. It is a building similar to those around it; a refugee centre, a group home and a medical centre. It is, however,

[††] All the above detention categories and requirements are listed in: Rikslagen (State Law) 1996:1379

[‡‡] An amendment was made in 1996 changing the rules for children in detention from 16 to 18 years. Immigration and Refugee Policy, Ministry of Foreign Affairs, 1997, page 29

fitted with special locks and alarms and detainees only have access to the inner part of the building.

The centre of the building has a small yard used for recreational activities such as soccer and volleyball. Detainees share their rooms and have their own keys to their room. Each room consists of a number of beds, a chest of drawers, a window and a tape player and radio. Rooms for women and families also include a bathroom. The communal areas of the building include a games room, mess hall, computer and TV rooms, bathrooms, laundry and library. The kitchen is generally locked up but access is given to clients wanting to use the kitchen. All knives are locked up to reduce the incidence of suicide attempts. The basement has interview rooms, the nurses room and a gym, which can only be used under supervision. There are two visitors rooms and a waiting room, with visitors welcome from 9am until 4pm, normally at a maximum of one hour per visit. Longer times are permitted for visiting children or if the person is to be deported.

The detention centres employ people from a range of cultural and professional backgrounds including social workers, social anthropologists, counsellors and mental health professionals, as well as people with experience working in closed institutions. One person is employed to organise recreational activities for the detainees.

All detainees are given a caseworker, whose primary role it is to inform them of their rights and to ensure that their rights are upheld while in detention. This includes ensuring they have access to a lawyer and that family members are informed that they are being held in detention. Asylum seekers are also informed about the procedures relating to their visa application or deportation procedures.

Staff are regularly given training in relation to refugee law, human rights, discrimination and occupational health and safety.

Non-government organisations and religious clergy have unrestricted access to asylum seekers, and are able to provide feedback to detention centre management. The media also has open access in the detention centre.

Detainees may be removed for emergency hospital or dental visits. Two caseworkers accompany the detainee without the use of any restraints. If detainees are required to stay in hospital for an extended period, they are signed out of the detention centre, otherwise staff will work in shifts to observe the detainee.

In cases of extreme depression where staff are concerned the detainee may attempt suicide, detainees are taken directly to the psychiatric emergency ward or caseworkers are stationed in the detainee's room in shifts throughout the night. A mental health professional speaks with them during the day and may prescribe anti-depressants.

Once a week detainees meet with their caseworkers to discuss changes in policy at the detention centre, and to discuss any concerns and suggestions. Detention centre staff consider the feedback on a weekly basis, and the manager of the detention centre is

present at those meetings approximately once per month. Formal complaints can be lodged by detainees, either directly to the Director or Supervisor of the centre, or directly to the Immigration Department's Asylum Bureau.

Reception Housing

Once released, asylum seekers are placed in Refugee Reception Housing and can then choose to either stay at a Refugee Centre or move in with friends or family in the community while they await a decision.

Approximately one half of asylum seekers in Sweden live in government-funded housing while their applications are being processed.[98] The government provides monthly allowances to asylum seekers without any means of support. Asylum seekers whose applications are expected to take longer than four months may receive work permits.

The Swedish Board of Integration sponsors language training, job placement and housing programs.

4.1.3 United Kingdom

Despite having more rigid policies in relation to asylum seekers than the rest of Europe, the United Kingdom does not place all unauthorised arrivals in mandatory detention for unlimited periods of time.

In its White Paper "Secure Border, Safe Haven"[99], the Home Office outlined the model of care for asylum seekers which is currently being implemented and will be evaluated over the next few years.

Asylum seekers are initially placed in Induction Centres where they receive a briefing about the asylum seeker application process, are given information about access to legal advice and receive basic health screening. The time spent in Induction Centres is approximately 1-7 days.

The Government is currently establishing Accommodation Centres (like those used throughout Europe) for asylum seekers whilst they wait for their applications to be processed and during any appeals. The Centres are being established on a trial basis, and will provide full-board accommodation and services relating to health, education and interpretation. They will also have access to legal advice. Asylum seekers will not be detained in those Centres, they will be free to come and go, and will receive a small cash allowance.

At this stage, Accommodation Centres are being trialled, and so not all asylum seekers will have access. Those not selected for placement in those Centres are placed in 'dispersal accommodation', which is government-assisted accommodation outside London.

The Home Office has convened the Unaccompanied Asylum Seeking Children's Stakeholder Group, with representatives from local authorities, NGOs, voluntary organisations and the Department of Health. This Group meets quarterly and is the main forum for the consideration of policy relating to unaccompanied children.

The UK has some detention centres. The Oakington Reception Centre is used to detain asylum seekers when it is likely that a decision will be made quickly and that their application will be rejected. The aim is to fast-track the process to ensure that asylum seekers are not kept in detention for long periods of time, and therefore the goal is to have an average time-frame of 7-10 days. Asylum seekers waiting to be removed from the UK are placed in Removal Centres.

Individual and families may detained for longer periods of time under certain circumstances, for example, during a security check or if there is a reasonable believe that the asylum seekers will abscond. However the White Paper[99] states:

> "…in the case of families…detention should be used only when necessary and should not be for an excessive period…Where families are detained they are held in dedicated family accommodation based on family rooms in Removal Centres."

It is important to note that there are concerns about conditions in detention centres in the UK. Earlier this year, a fire and riot at the newly-built Yarlswood Detention Centre led to a call for a review of the substandard conditions and long detentions of people who had not committed any crimes.[100] The United Nations High Commissioner for Refugees spokesperson, Kris Janowski, stated his concern about the grouping together of asylum seekers whose claims had been rejected with those whose applications were still pending.[101]

4.2 Canada

Like Europe, Canada does not have a policy of mandatory non-reviewable detention for unauthorised asylum seekers.

Current legislation states that asylum seekers may be placed in detention if they are "likely to pose a danger to the public" or if "the person is not likely to appear for an examination, an inquiry or removal."[102] The Act states that detention is a preventative rather than punitive measure. Decisions regarding detention will be reviewed after 48 hours, with further reviews scheduled after seven days and each subsequent 30-day period.[103]

The Canadian government has proposed regulatory provisions[104] to clarify the grounds for detention, and to assist in the implementation of the Immigration and Refugee Protection Act (which is expected to occur in June 2002)[105]. These regulations state that "a minor child shall be detained only as a measure of least resort", and that "the best interests of the child be taken into account in detention decisions involving minors."

The Canadian Council for Refugees voiced concerns about several aspects of the regulations, particularly those relating to the circumstances by which minors may be detained; that is, where there are questions about identity or where there are fears that minors might fall into the hands of traffickers.[106] It called for the revision of the regulations so that "minors are rarely, if ever, detained", and for the use of "safe houses" rather than detention centres.

The Inter-American Commission on Human Rights also criticised the proposed legislation, stating that it would rely more heavily on detention, and that treatment of refugee claimants was "illegal by international standards".[107]

Asylum seekers in Canada receive a variety of social services including income support[107], health services, work rights and education for children.[108] Charitable organisations such as VIVE La Casa provide assistance such as shelter, food, medical care and legal services.[109]

5. RECOMMENDATIONS

1. From its focus on the physical and mental health needs of children and their parents, and the best available evidence relating to the impact on children of Australia's current mandatory detention policy for asylum seekers, the Alliance concludes that children should not be held in anything other than minimal detention for processing purposes only.

2. Recommendations for the immediate future are that:

    a) all children and their families who do not constitute risks to national security or the community be removed from detention and placed in the community or an open detention environment with access to all necessary services including health, welfare, education for children and language skills for carers (as a first step to this goal, all children and their primary carers should be immediately removed from detention)

    b) there be an immediate clinical review of the physical and mental health status of asylum seekers in detention (Clinical Review) undertaken by independent health professionals (under the auspices of the Committee of Presidents of Medical Colleges) to gain a better understanding of the health status and needs of those asylum seekers. This would include a comprehensive assessment of children taking into account their bio-psycho-social-developmental and educational needs

    c) the companies managing detention centres cease requiring health professionals/staff to sign confidentiality agreements, and cancel such clauses in existing contracts

    d) a National Summit on Asylum Seekers be convened (under the auspices of an independent organisation such as the Alliance or a consortium of its constituents). The major task of the National Summit would be to call for submissions about Australia's policies in relation to undocumented asylum seekers (including detention and community-based issues), examine the results of the Clinical Review, examine barriers to good policy (eg jurisdictional and workforce/remuneration issues relating to child protection, health services etc), and establish a working party to propose specific policy reforms.

3. Asylum seekers who enter Australia without travel documents in future should be placed in processing centres for a limited number of days before being released into the community. Being released into the community can include being housed in reasonable communal accommodation provided they are situated in centres of population.

5.1 Consultation & intersectoral collaboration

Strategies should be implemented to facilitate intersectoral collaboration in relation to these issues. Some examples are:

5.1.1 Consumer and professional collaborative groups at the local level

Active partnerships should be developed between asylum seeker/refugee groups and deliverers of health services to ensure that the needs of asylum seekers are met in a culturally appropriate way. One such group was set up in Brisbane[110] and consequently an integrated Asylum Seeker and Refugee Health Clinic was set up with a focus on outreach services and consumer participation (with a seeding grant from Queensland State Health). This involved a close collaboration between many local asylum seeker and refugee groups, the local Torture & Trauma Service, GP Divisions, Community Health, a local network of doctors and allied health workers (Brisbane Refugee Health Network).

5.1.2 Professional health networks and collaboration

Networks of professionals interested in the health of asylum seekers/refugees and their children are forming in many of the major centres around Australia. These groups should be encouraged, fostered and broadened to include community health and mental health organisations, nursing organisations, psychologists, social workers, dentists, pharmacists, occupational therapists, physiotherapists, hospital administrators etc. Two such networks are the Brisbane Refugee Health Network (which has about 60 members) and the NSW Refugee Health Improvement Network. The latter operates under the auspices of the NSW Refugee Health Service and meets bi-monthly with approximately 70 individual members from a range of health services and non-government organisations. More recently, at the national level, this Alliance has collaborated with other member groups to produce this submission and is prepared to assist in the establishment of an ongoing network at a national level.

5.1.3 Conferences on the health of asylum seekers/refugees and their children

Such conferences facilitate national and international exchange of ideas and information, and allow many people to learn from initiatives tried in many other parts of the world facing similar dilemmas. Discussion on the health needs of asylum seekers and refugees should be included in major health conferences around Australia.

5.1.4 Workforce training

All medical and health science courses should contain coursework relating to the physical and mental health of asylum seekers and refugees, and the developmental and mental health implications for children in these groups. The connections between human rights and health should be more firmly established in the ethical components of these courses.

Primary health care training should include placement in asylum seeker/refugee health clinics. Key competencies for working with refugees and asylum seekers are already documented.[111]

5.2 Temporary Protection Visas

Asylum seekers who enter Australia without travel documents and are recognised as refugees should be granted permanent protection visas. Australia's current policy of granting Temporary Protection Visas is a major barrier to re-settlement in the community.[112] They should be treated in the same way as other refugees in Australia, who are given access to Medicare, public housing assistance, employment services, education rights for children, interpreter services, language classes, Migrant Resource Centre support, and the right to seek reunification with other family members.

5.3 Release into the community

In May 2001, DIMA launched a trial of alternative detention arrangements for women and children at Woomera[113] involving placing them in houses in the town of Woomera (with 24 hour supervision), whilst a family member (usually the husband or father) remained in the detention centre. This trial is currently being evaluated, but there has been a conspicuous lack of interest in the experiment because families do not want to be separated.[112]

The Alliance does not support policies that separate families and proposes a more humane approach to the handling of undocumented or informal asylum seekers arriving in Australia or its environs, consistent with Australia's historic compassion for people under stress.

5.3.1 A more flexible detention regime

1. The Alliance supports a model along the lines developed by the Refugee Council of Australia[114], which provides a legislative and regulatory framework for a more flexible detention regime similar to models currently used in Europe and Canada.

2. Under this model, restrictions of the current type on the liberty of protection visa applicants would be kept to a minimum number of days. After an initial period in closed detention, most applicants would pass on to a more liberal regime most appropriate to their circumstances. Regular review of each applicant's detention status is recommended so as to improve the ability to relate the applicant's circumstances more equitably to the restrictions imposed on his/her liberty. Finally, a review process is recommended to establish a higher level of equity in the case management of each applicant.

3. This alternative model proposes a simple three stage regime representing a linear progression from severe restrictions on personal liberty to increasingly liberal provisions:

i) Closed Detention

This proposal represents the most severe form of detention. All applicants who have not been immigration cleared would be initially held in closed detention. During this initial period, which should only be a limited number of days, the applicant's identity and circumstances would be established to the point where a decision can be made about the most appropriate form of detention. It is envisaged that all persons other than clear security risks would be moved within days to one of the two more liberal detention regimes as appropriate to the individual's circumstances. Longer closed detention should be open to independent judicial review as to whether the circumstances first justifying detention persist. If they do, the decision should be reviewed every 30 days of detention. As soon as it is independently determined that the original justification for closed detention no longer exists, the applicant would be released into open detention or into the community.

Closed detention should be under the control of DIMIA in facilities such as currently exist at Villawood/Westbridge (New South Wales), Maribyrnong (Victoria) and Perth Airport (Western Australia). All detention facilities should be located within or close to major urban centres where appropriate specialist services are available. They should be open to visitors and the media. DIMIA should state in its contracts with centre management that health professionals/staff shall not be required to sign confidentiality agreements. Facilities are to meet transparent national standards of health care and address the particular needs of the population (eg following trauma). The level of health care should take into account the human rights needs of all detainees according to international treaties on human rights and subsequent conventions (eg United Nations Convention of the Rights of the Child). Independent legal advice should be freely available.

(ii) Open Detention

This intermediate regime would house those applicants considered to be unsuitable for community release as judged by an objective independent panel because it was not in the interests of either the community or the applicant. Freedom of movement would be restricted only by curfew requirements. Residential facilities would be maintained and regulated by DIMIA. These places should be open to visitors and the media. Full access to health care and legal advice should be available.

iii) Community Release

This proposal represents the most liberal form of detention. Community release would be to families, responsible members of the community or community organisations (such as churches), or upon the applicant's own recognisance, which may also be guaranteed by other persons or organisations. DIMIA would

not be responsible for the accommodation and welfare of the applicants, but family members, community organisations or other suitable individuals will undertake major responsibilities of caring for the persons in their charge. Restriction on personal liberty would be limited to the requirement that each individual reside at a designated address and report periodically to an appropriate authority. If necessary, the reports may be verified by the person or organisation responsible for housing the applicant.

4. This alternative detention model would enable the responsible authorities to move applicants over the range of detention stages so as to suit changing circumstances as well as in response to past behaviour. More details about this model are available in the report 'Alternatives to Detention'.[114]

5. The Alliance recommends that children and their primary carer/s take priority in the review process, and that they be considered for community release promptly after arrival.

5.3.2 Services required in the community

1. Services for asylum seekers and refugees, especially children should be in line with general community standards and Australia's obligations under domestic law and the various international treaties to which we are signatories as a nation.

2. Education services for unaccompanied minors, children of asylum seekers and refugees are particularly important. Schools with significant populations of asylum seekers/refugees should have human rights education to ensure that these children do not suffer discrimination and bullying from other children. A good model has been developed by Amnesty International Queensland Schools Network which provides education programs in over 140 schools throughout Queensland.[115]

3. Asylum seekers and holders of Temporary Protection Visas should be treated in the same way as permanent refugees in Australia, and be offered:

    - access to Medicare
    - public housing assistance
    - employment services
    - education rights for children
    - torture & trauma counselling
    - interpreter services
    - English language classes
    - access to Migrant Resource Centre support
    - unrestricted independent legal advice

4. More detailed recommendations in relation to these services can be obtained from the Brisbane Refugee Health Network.[115]

5.3.2.1 Health needs of asylum seekers living in the community

1. The following two paragraphs have been copied from the article 'The health needs of asylum seekers living in the community' by Harris and Telfer in the Medical Journal of Australia:[47]

   > "The Victorian Foundation for Survivors of Torture and the West Melbourne Division of General Practice have produced a guide to the care of refugee patients in general practice.[116] This emphasises the importance of engaging a professional interpreter and providing adequate education and information to refugee patients, including the cost of prescriptions, investigations and referrals. Key issues to be considered in the assessment include preventive care, chronic conditions for which management may have been delayed or inadequate, dental care, developmental problems, mental health problems, injuries and infectious diseases.
   >
   > The aims in managing refugee patients who may be survivors of torture or other trauma associated with refugee status are:[111]
   >
   > - to identify patients who may have experienced torture and/or traumatic experiences
   > - to understand the context in which torture and refugee trauma may have occurred, and the impact on the individual, family and community
   > - to assess the physical and mental health problems of torture and refugee trauma survivors
   > - to work with patients to develop a management plan
   > - to be aware of and confident in referring patients to appropriate services"

2. On the basis of the clinical evidence, it is clear that refugee children should be kept with their families and receive appropriate specialist mental health intervention and support. Traumatised parents should also receive adequate mental health treatment so as to enable them to care for and nurture their children in times of great stress.

3. The most prominent need of asylum seekers living in the community is to be able to access medical services and affordable medications. This group of people cannot afford to pay for health services, and as a consequence make decisions regarding health care based on their ability to pay. Apart from issues of humanity and compassion, late presentations and poorer health outcomes will ultimately cost the community more than providing access to appropriately subsidised health care in the first place.

5.4 Improvement to services in detention centres

The Alliance recognises the practical impediments to immediate policy change. However, it submits that whilst Australia retains any policy of mandatory detention for asylum seekers, conditions in our detention centres (on and off-shore) must be improved immediately.

5.4.1 Systematic Independent Review by Clinicians

1. Australia should adopt a policy of systematic independent review of health services and conditions in detention centres by clinicians, based on the model developed by the Council of Europe. The Council of Europe convened the European Committee for the Prevention of Torture (CPT) which visits places of detention throughout Europe and then makes recommendations about any necessary improvements.[117] The composition of the CPT is multi-disciplinary (eg lawyers, medical practitioners and prison experts), and its role is to examine the treatment of people placed in detention. It is entitled to visit any such place and interview, in private, any of the people detained.

2. The Alliance proposes the following model for Australia, based on the guiding principles of cooperation and confidentiality:

    - A Detention Centre Clinical Review Team (Review Team) should be established under the auspices of the Committee of Presidents of Medical Colleges (CPMC) and funded publicly but otherwise independent of government.

    - The Review Team would be multi-disciplinary but would primarily consist of clinicians: eg public health physician, paediatrician, adolescent health physician, psychiatrist, child psychiatrist, adolescent psychiatrist, general practitioner, social worker, psychologist, and include a professional who works in a refugee health service and a lawyer.

    - The mandate of the Review Team would be:

        a) to visit all places of detention of asylum seekers located both in Australia and off-shore, with a view to examining the standards of care such as human rights provisions, physical and mental health care, and legal services

        b) where conditions are considered inadequate or inappropriate, to make recommendations for improvement within a feasible time frame (including a follow-up and review strategy)

- The Review Team would visit each detention centre at least once a year with two or more Review Team members accompanied by other experts, members of the Review Team's Secretariat and interpreters.

- Review Team delegations may organise additional 'ad hoc' visits if necessary. The Review Team would notify DIMIA and the management of the detention centre of proposed visits, but need not specify the period between notification and the actual visit. Government or centre management objections to the time or place of a visit could only be justified on grounds of national defence, public safety or serious disorder.

- Review Team delegations would have unlimited access to places of detention and complete freedom of movement within them. They could interview detainees without witnesses and have free access to anyone who could provide information.

- Recommendations of the Review Team would be reported and form a basis for dialogue with DIMIA and/or management of the detention centre.

- The guiding principles would be cooperation and confidentiality, the objective being to protect detainees rather than condemn government or management. Hence the Review Team would meet in private and its reports would be strictly confidential. However, if the department/centre management refuses to cooperate or fails to improve the situation in the light of the Review Team's recommendations, the Review Team could make a public statement.

3. This Alliance is willing to further develop this proposal in consultation with relevant authorities.

5.4.2 Health Services

1. The physical environment of the detention centres greatly influences the health of detainees. DIMIA and detention centre management must provide basic humane standards and should strive to achieve world best practice in all Australian facilities as a matter of urgency. Facilities should accommodate the language, cultural and religious needs of detainees.

2. Detention centres should provide suitable health facilities with appropriate equipment and trained staff, or arrange for such services to be made available, for the continuing treatment and care of all detainees.[118]

3. Every detention centre should have at least one medical practitioner on call and available twenty four hours a day to attend to detainees. Medical services should be organised in close relationship with the general health system and should include access to psychiatric and pharmaceutical services. Detainees requiring treatment which cannot be provided adequately and safely within the detention centre should be

transferred to appropriate facilities. Where hospital facilities are provided within a detention centre, equipment, accommodation and pharmaceutical supplies must be adequate for the medical care and treatment of detainees.

4. On the basis of the clinical evidence the Alliance has gathered, it is clear that refugee children should be kept with their families and receive appropriate specialist mental health intervention and support in detention centres in a culturally sensitive manner. Traumatised parents should also receive adequate mental health treatment so as to enable them to care for and nurture their children in times of great stress.

5. Detainees should have ready access to psychiatric services within the detention centres. Medical practitioners with suitable qualifications and experience in psychiatry should be represented at the policy-making and decision-making level in the administrative structures of all health authorities administering services in detention centres, and should be involved in the day-to-day management of detainees suffering from psychiatric disorders. Detainees with a severe psychiatric illness should be moved to an appropriate psychiatric facility.

6. Suicide prevention and the management of suicidal behaviour are major health and management issues in detention centres. Links should be forged between the Immigration Detention Centre Advisory Group, the National Suicide Prevention Advisory Council and other national mental health advisory bodies, to ensure that best practice policy advice is provided to companies managing detention centres. Threats of suicide by detainees should be taken seriously and treated humanely. Efforts should be made to minimise self-harm by providing an appropriate environment which includes supportive human contact. A detainee should not be put into seclusion solely on account of suicidal ideation. When a detainee is identified as being at significant risk of suicide, the attending staff should arrange for the detainee to communicate with someone trusted, including family members and other appropriate people outside the Centre as appropriate. Solitary confinement, by which a detainee is confined separately from detainees as a means of punishment, is inhumane and should be used only in highly exceptional circumstances. Solitary confinement can lead to a number of physical and/or mental disorders. The current tendency of authorities to minimise the seriousness of self-harming behaviour, or to dismiss such behaviour as manipulative, is a stereotype which should be avoided.

7. A detainee may need to enter protective custody if at risk of self-harm or of harm by other detainees, or may need to be separated for infection control if with a blood-borne or sexually transmitted infection. In such cases, the detainee should be separated from others but placed in an environment similar to that of the other detainees. When a detainee is isolated from all other detainees, s/he should be provided with the opportunity to have regular contact with people outside the correctional facility environment preferably face to face. In urgent cases, telephone contact with a suitably trained person should be arranged.

8. Health screening of detainees should be undertaken by a medical practitioner or a nurse. Health screening for addictive, physical and psychiatric problems, including potential suicide risk, should occur within six hours following admission to a facility. All significant medical findings should be referred immediately to a medical practitioner.

9. All medical management of detainees should be undertaken by a medical practitioner. Access to adequate resources for the management of medical conditions detected in the screening process should be available to detainees. All detainees should be offered immunisation for Hepatitis B and other similarly preventable infectious diseases and there should be systematic on-going health review for each individual detainee.

10. Female detainees should have access to ante-natal, obstetric and post-natal care and gynaecological health services in a culturally sensitive manner. Children should have access to appropriate paediatric services. Asylum seekers should receive advice on reproductive health and sexually transmitted diseases.

11. Every health care service in a detention centre should be a part of the general health system and independent of Departments of Corrective Services or their equivalent and should seek accreditation through the Australian Council of Health Care Standards.

12. In the process of privatisation of the on-going management of health care services in detention centres, economic decisions should not take precedence over the quality of health care and human services provided to detainees. It is the Government's responsibility to establish and monitor publicly accountable standards.

13. The medical profession has an obligation to educate people working in detention centres to understand and manage the health needs of detainees appropriately. Professional medical bodies have a responsibility to support detention centre practitioners as much as possible, and to provide on-going training and other professional activities for them.

14. Incarceration increases the risks of sexual and physical assault. Adequate resources should be provided for preventing such assaults from occurring. For those who have been sexually and physically assaulted in detention, appropriate counselling should be provided.

15. Where a detainee refuses nourishment and is considered by the medical practitioner to be capable of forming an unimpaired and rational judgement concerning the consequences of a voluntary refusal of nourishment, the practitioner should refuse to co-operate in artificial feeding. The decision as to the capacity of the detainee to form such a judgment should be confirmed by at least one other independent medical practitioner. The practitioners must explain to the detainee the consequences of the refusal of nourishment.[119]

16. It is important that family units be kept together as far as possible and that some semblance of normal life be provided, particularly education and age-appropriate recreation. In circumstances where the parents must stay in detention while the children go into the community, there must be a coordinated and strategic approach to secure access by parents and children to each other, and to ongoing care for the children. For children in detention centres without family, the risks to health are multiplied. These children should not be in a detention environment at all.

5.4.3 Other services

1. Agreement between state and federal government authorities on the conduct of detention centres is urgently needed to protect the children. The agreement reached should be made public so that the community can be satisfied that those levels of child protection have been put in place by the responsible authorities. In responding the child welfare notifications, state government child protection services should have immediate and unfettered access to children within a 24 hour period without the need for approval from detention centre management. Recommendations of child protection services should be acted upon in a timely manner. The intergovernmental agreement should embrace appropriate sanctions on authorities found to have abused children or neglected their needs.

2. Children of asylum seekers in detention should receive good quality education services, especially English language skills, and generous access to a range of recreational opportunities and facilities.

3. Children should be given thorough developmental and growth screening (including for infectious diseases particularly eye and gastrointestinal infections) on arrival, and thereafter every 6 months. Full immunisation of all children should be offered on arrival. Nutritional assessments should also be provided and nutritional supplements should be provided to children who have a history of malnutrition.

4. Pregnant women should receive full antenatal services, including hospital care prior to giving birth. Full postnatal care should be provided, including the promotion of breastfeeding and postnatal check, immunisations etc as for women living in the community. Nutritional supplements should be provided to pregnant and lactating women in accordance with Australian Dietary Guidelines.

5. All medical/health consultations should be provided with an accredited interpreter, and management or departmental staff/guards should not be present during medical consultations. Female consultants should be available where appropriate.

6. Access to health services within detention centres should be free and unobstructed. Systems for accessing health services should be set in process so as to enable detainees to access medical services without having to seek permission from a guard.

7. People in detention should be enabled to understand their rights, have liberal access to independent legal advice, and receive regular briefings about the status of their visa application.

8. The secrecy and seclusion presently associated with detention centres should be immediately lifted. Facilities sited away from major centres of population should be closed and the detainees moved to places where family and community visits and the delivery of human services are convenient. Lawyers, medical practitioners and others with legitimate interests in detention centres should be given liberal access and the media admitted.

Appendix 1

Case study: personal account of a father during hunger strike

Statement from Ms Trish Highfield, child-care worker, concerning Mr Heman Baban and his son who was aged under three years, about a protest and hunger strike in Port Hedland:

> "Mr Baban had been detained since June 1999 for refugee case administrative purposes and escaped from Villawood IDC in 2001. His whereabouts is unknown.
>
> Mr Baban told me of his experiences when, following a protest hunger strike, he and his young child ('child F') and others were roused without warning during the pre-dawn to be flown for most of that day to Port Hedland. In a written account of the hunger strike, officers tried to leg-cuff his little boy. After arriving in late afternoon they were given no food or beverages until the following morning at 0800. Mr Baban told me that there were no toilet or water facilities in the small room in which they were held. Despite repeated requests they often had to wait for up to an hour before being escorted to the toilet. Mr Baban was forced to allow his child to relieve himself on to a bundle of clothes in the corner, which he would later wash out. He expressed concern to me that his child was suffering from the experience of being confronted by aggressive staff and of being confined in a small room for 14 days. The child was constantly crying and asking to go outside."

The following is an edited[#] detailed account provided by Mr Baban to Ms Highfield:

> "As a result of the asylum seekers arbitrary detention policy of the Australian Government, dozens of the desperate detainees (85-65) sent a protest letter to Prime Minister via the Minister of Immigration declaring their decision to embark on a 'Hunger Strike'. Basically they were expressing their protest inside the centre; spending most of the time inside the recreation room (RR); arranging some peaceful demonstrations without hurting anyone else; and provided there were no written rules, they refused a request by the central manager to attend the muster or to stop their demonstrations.
>
> One of them had a severe case of diabetes. Demonstration chants included: "We are refugees not criminals"; " No more with DIMA"; "Philip Ruddock has to go"; "No more detention", and others. Most of the detainees had spent around one year in detention without their cases being decided upon, a few others had been here as long as three years, but the minimum was four months.
>
> Monday 24 July 2000
>
> The first day of the protest.

[#] Names of individuals have been removed, and grammatical errors were corrected.

Tuesday 25 July 2000

A representative from DIMA promised the protesters a hard time and threatened that he would stop processing their cases if they continue. They did. We thought the officers were going to take one of the protester's children away, but the protestor managed to take the children with him inside.

I told the lines writer that there were up to six mates inside the RR who were very exhausted, but they were not receiving sufficient medical treatment. He told me that one protester had cut his belly and the bleeding continued from 6pm until 2pm the next day while the nurse refused to dress his wounds unless he came out, in the rain. The next day the detention centre doctor accused the nurse for being merciless and incompetent. The doctor explained to the protesters that it would be better if the man went to the medical centre, and so he was escorted there. The detention centre manager rudely told the men to stay out of the medical centre. When they refused he ordered his men to force one man against the wall, gripped the protester's face with his hand, and wouldn't let him go back until the other protestors came out threatening to cut themselves with razors. Only then did he let them all go back.

Wednesday 26 July 2000

All the visits, phone calls, and faxes services were stopped since morning. The only four working public phones had been disconnected by Telstra. Although we were inside one of the most affluent western countries, we were actually isolated from the rest of the world. The officers, most of the time, wouldn't let any detainee go to the main office, where any administrative procedures, including those of the immigration, were handled. The centre manager came again and ordered us to leave the RR and go our rooms otherwise he would force us to attend muster 3 times a day.

We realized that if we attended muster and allowed the officers to enter the RR this would enable them to deal with us one by one. The detention manager's tone of voice was threatening. One of DIMA managers came with two officers accompanied by other ACM official carrying a videocam. We let them inside for negotiation. At first he asked to listen to some of us separately for he had a lot of time and he thought that our demands were very individual. We told him that our spokesman would speak for us. This manager said that he had been to all the detention centres where other hunger strikes had been conducted, and that we had been cheated by the smugglers who deliberately underestimated the miserable detention centres in Australia, difficulty in getting refugee status, and to make sure that our relatives overseas were getting this message. He also said that hunger strikes were useless (didn't pay off), and that asylum seekers were usually recognized as refugees (granted a visa) within weeks or months. Here I added — as

a comment — "or years", and then he stepped towards me in an aggressive manner and told me to shut up.

Our spokesman told him that we were disappointed, because we were expecting a DIMA executive at a higher level to speak with us. The Manager apologized to us about his behaviour. They told one detainee that his wife was at the hospital and she needed him. He left the RR, escorted by two officers, and we have not seen him since then.

Friday 28 July 2000

In the morning, two of the protesters tried to hang themselves, and demanded that the officers around the RR move away. But the officers stayed there. One of the protesters tried to hang himself. Immediately his friends jumped to relieve the rope while another one had lifted him up. After the resuscitation he was unable to speak properly for about an hour and had difficulties breathing. It was still morning when management cut the power. At 2pm they cut the tap water supply. At 3pm management brought 2 bottles of spring water for us to drink. We noticed that the seals on the bottle caps had been broken, however we had no other choice than drinking that water. We let 'Dr F' (with one of the ACM managers and 2 officers) come into the RR to treat two detainees.

Dr F said that the Minister and the media had heard about and understood the purpose of the protest and that we should end it now before they had to take strict and radical counter measures. We asked that they treat the detainees who were sick, tired and afraid and we offered to make the muster once a day as long as the ACM promised to withdraw the Riot Squad. They promised they would put this deal to the Head Office. We explained that we had nothing against ACM, and that our actual motive was to be heard by the Government and the Minister.

At 4.30pm the Centre Manager stated that he would not agree to the proposed deal, and that he would respond harshly. At about 6pm the tap water supply was turned on.

At night myself and another detainee (we had not drunk the bottled water) noticed that the rest of the protesters started to behave in a strange manner. They were laughing, talking non-sense (inconsistent speech), and seemed as they were not aware of what they were doing. Around 12pm, other protesters, and I could hear the riots continuing outside.

At about 2.30am I heard statements such as "Nobody should move", "If anyone does, we will use the strongest available force, and will beat you without giving a sh...". I thought that they were very serious and might even hurt our children so I was the first one to leave the RR carrying my child. At the Golf Gate, one of the men handcuffed me, and I asked how I would carry my child with the handcuffs, but he forced me through the Gate with a strong push, so I ended up carrying my

child with a handcuffed hands. They gathered us in the dining room when one of the officers freed my hands, but I was re-handcuffed again by another officer shortly after. A tall, well built officer (I had not seen him before) dragged me by my hair, pushed me against the wall, and searched my body in an unjustified humiliating way after pushing my child towards the corner who began to scream and cry. He handcuffed me again and tried to legcuff my child when I jumped helplessly to protect my child. Two other officers prevented him from legcuffing my son. All the other protesters in the dining room had been searched in the same manner, handcuffed with plastic handcuffs, and some of them with both steel and plastic handcuffs.

I did not recognise most of the officers who handled us with such a brutal measures, except for two of them who had abused us both physically and verbally (swearing, shouting and kicking us when we were on the ground). Those two officers were 'Officer X' and 'Officer Y' from the ACM.

Five minutes before they took us to the bus they tried to take my child from me, and I became furious. All the protesters objected and we managed to keep him with me. On our way to the Airport, they prevent us from looking through the windows (we were not allowed to shift the curtains to watch), but we noticed, through the windscreen, that the driver is taking backstreets, not the main roads. The escorting officer said that they did not want anybody to see us. At the Airport, after getting off from the bus, one of the riots pushed me fiercely forward, knocking me to the ground and on the top of my child whom I tried to protect. As a result my left arm was injured. I received another push on my way to the airplane stairs, and so did some other detainees.

On the plane there were 14 men, one woman, and four children escorted with about 15 officers. One of the officers waved a medical vial in his hand, threatening to inject us with the sedative drug if any of us moved or looked through the window. We arrived at Port Hedland airport about 4pm. One of the detainees was taken away, we don't know where.

We were each placed in individual cells in the Port Hedland DC's Isolation section. Each cell had no windows and nothing at all inside except for the bed and one iron door with small hole in it for observing and for face-to-face contact. It was not until 8am the next day when they gave us food for the children to eat. The children started to cry. When I asked for food for my child, the officer told me that I had to wait.

The next day they tried to take the children and put each one in a separate room. We disagreed with this. For the next 5 days they took my child 3 times a day, put him in a separate cell with food for him only and returned him when finished. I had been approached by DIMA officers several times in order to discontinue my hunger strike, but I explained that I would not do this until I was released from detention.

On the 5th day, a DIMA officer said that if I continued the hunger strike I might spend the rest of my life in that cell, and nobody would know about me. They promised that if I discontinued the hunger strike, they would move me to general section of the detention centre.

I discontinued my hunger strike 5 to 6 days later, however they did not move us to the general population as they had promised. During those 13 days we were not allowed to go to the toilet, unless escorted by an officer and had to wait up to one hour on some occasions.

On the 12th day they took me to an office there where I met my lawyer who explained to me few details about my next Federal court hearing session. Since I had arrived there I had tried (demanded) to contact my lawyer and a few of my friends in Sydney but the officers had refused absolutely. No communications were allowed for me. I insisted to make phone calls and tell my family and friends in Sydney about my situation, but they told me this was not allowed without DIMA consent.

On the 9th day I requested (by frequently asking the guarding officer) to see the supervisor early in the morning, but at 4pm he told me that the supervisor would not come to see me at all. I got the impression he was not passing any messages at all to his supervisor. I became so furious, but I kept quiet until I made sure that my child was taken away from the cell when I threatened to cut myself with a blade I smuggled with me.

In less than a minute the supervisor was with me negotiating. He offered to let me make a phone call if I gave him the blade. He kept his promise. Four days later they transferred me back to Sydney Villawood Detention Centre to attend my Federal Court hearing date.

I had spent those 13 days totally in that cell with my child. I still can't believe that I've been through that experience in the country in which I sought asylum.

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