

# National Inquiry into Children in Immigration Detention 2014

Melbourne Public Hearing

Wednesday, 2 July 2014

<b>President</b>	<p>Well good morning everybody, thank you for returning so promptly. Before I begin I thought I might explain the roles of my colleagues who are here with me at this inquiry. Fabienne Baldan is the Director of the inquiry within the Australian Human Rights Commission and Prabha Nandagopal is the Senior Legal Adviser who is providing the legal advice which of course underpins all that we do at the Australian Human Rights Commission. They and others from the Commission are here today to support this inquiry and to provide the technical and other skills that are necessary to run an inquiry which is very detailed and must be accurate both as to law and as to evidence and that is of course something that underpins the success of any inquiry and I hope most particularly this one. So we have heard some very moving evidence this morning and we've heard of some things that frankly I was not aware of before the inquiry, so these hearings today are already proving to be important in terms of the kind of evidence that we are receiving. But I would like now to move to the International Health and Medical Services group who have come again for the second time, if I can thank Dr Mark Parrish, not only for coming to a second hearing, but also for working with our Human Rights Officials from the Commission to understand the nature of the medical services and of the mental and physical wellbeing of the detainees, particularly children. So we've greatly appreciated your co-operation and your willingness to listen and to think about your own provision of services. I want to make that clear before we begin because we are going to be looking at some evidence and processes that are certainly challenging. Perhaps we could begin then with the oath.</p>
<b>[oath]</b>	<p>Oath taken by Dr Parrish, Dr Gadd, Mr Gilbert and Ms Lysaght.</p>
<b>President</b>	<p>Thank you Dr Parrish. Would you like to begin with an opening statement?</p>
<b>Dr Parrish</b>	<p>Please if I may, thank you. Thank you for the opportunity to appear today and answer your questions relating to the health and medical services that International Health and Medical Services provides to children and their families in Australian Immigration Detention Facilities. Before we answer your questions I would like to introduce myself and my colleagues and also</p>

give some details about the services that you've seen operating in the various Detention Centres that you've visited. I'm Dr Mark Parrish, the Regional Medical Director for IHMS and I have overall responsibility for the medical aspects of these health services. My colleague, Ian Gilbert is the Chief Operating Officer and has the responsibility for the non-medical aspects of service delivery. Melissa Lysaght is a Director of Corporate Affairs and has co-ordinated the provision of information to the inquiry to date and Dr Ray Gadd is a general practitioner who has worked with us on Christmas Island as well as other sites. As professionals committed to the provision of services to people in immigration detention we acknowledge the health and the human rights concerns expressed by the Royal Australian College of Physicians, the Australian Medical Association and other peak health organisations and we share concerns for adverse health, particularly mental health effects of prolonged detention and especially on children. It's our role as health professionals to deliver appropriate health services to help people manage their health during the time they are in the immigration detention system and to advise the Department about health matters. If I can turn a little to the services that we offer, the IHMS teams at each site provide a range of services to those in detention facilities. These include health screening and assessment, preventive health care, integrated primary health care, health education and advice and access to secondary and tertiary health services as clinically indicated. Services are comparable to those accessed by the Australian community through the public health care system. Health care provided by us is designed to meet the standards for health services in Australian Immigration Detention Centres as published by the Royal Australian College of General Practitioners. And services at the larger detention centres including on Christmas Island, have been externally accredited to these standards. Our team is a multi-disciplinary one that includes general practitioners, psychiatrists, registered nurses, mental health nurses, psychologists and counsellors. We work in conjunction with local public health facilities to ensure the appropriate range of services. Our service to people in immigration detention has evolved over the past 11 years to match the changing make up of people accommodated in facilities and the policy environment, and there's been considerable development in the approach to the management of the health, mental health and welfare of all people, including children and young people who are in immigration detention. We maintain, and the Department respects, that our role as carers and service providers includes advocating for improvements where necessary in the treatment and care of those in detention. This happens at a systemic level, at a site level and for individual cases where particular needs exist. We note the objective of this inquiry is to assess the impact of immigration detention on the health, wellbeing and development of children

	<p>and these three objectives are prime concerns that we at IHMS share. As healthcare professionals, we are diligent in ensuring that we not only provide appropriate healthcare to all people in detention facilities, but we do so with a commitment to ensuring that we uphold the dignity and the privacy of each of our patients. Just to give you an idea of the scale of the service we provide, our doctors, nurses, mental health and allied health professionals hold around 20,000 consultations every month for a current population of about 4,000 people. On top of this we provide health education through group workshops, with a further four and a half thousand interactions with individuals each month. We employ more than 250 doctors, nurses and health professionals at sites throughout Australia and they're registered with their professional body through the health practitioner registration authority, as appropriate, and all the normal obligations regarding the duty of care and codes of conduct apply.</p>
	<p>We've worked closely with your Commission to ensure that we make available the information that you've requested. Our clinical staff have met with members of the inquiry at each of the site visits and described the nature of the services and health needs of children in immigration detention. We also met with your team at the public hearing in Sydney and twice in our offices. We've provided more than a hundred of our policies, procedures and forms which we use to govern the healthcare for children and which are referenced to relevant Australian standards. We've provided health status summaries for around 150 children and their families to help the inquiry gain a view of the health issues faced by these children and the care provided to them, and this has helped explore the differences in medical issues as reported by the Commission compared with what's been evidenced in health care records and reported by IHMS staff. We place great emphasis on proactive health care, both in terms of physical wellbeing and mental health. All children undergo routine health and developmental screening in line with state health guidelines and I'm delighted to say they're <i>[inaudible]</i> for these with any issues identified being treated. All families are offered vaccinations, and again we're pleased to confirm the vast majority of our children in the immigration detention system are up-to-date with their immunisations. We conduct extensive outreach programmes to engage with people outside the clinic environment to offer meaningful activities and to help individuals build resilience. This includes group programmes for adults and children in different language groups and with input from families to help build the programmes and schedules. For example, on Christmas Island we offer around 16 different group programmes each week that people can attend.</p>
	<p>On Thursday last week your team asked that we involve one of our</p>

	<p>psychiatrists to appear today. Unfortunately that wasn't possible at short notice and we'd be pleased to facilitate a separate meeting with members of our mental health team, including one of our child psychiatrists who consults with us. The inquiry has spoken with us at length about the access to allied health and specialist care, on Christmas Island in particular, and we manage this through a combination of visiting dentists, optometrists and specialists, the use of telehealth and by transferring patients to the mainland for particular specialities. We monitor access to be commensurate with the guidelines for speciality care as published by the West Australian Department of Health. And as we've reviewed specific cases we've found the vast majority of these services have been within guidelines, with the exception of optometry services which we acknowledge has had longer waiting times than we would expect, and we have introduced more frequent visits by an optometrist to Christmas Island. I hope that helps provide a general overview of our services and I now welcome your questions on the services that we provide.</p>
<p><b>President</b></p>	<p>Thank you very much Dr Parrish and I will ask a number of questions and then any one of your team might be happy to answer them. What I'd like to do is to look at your own materials that deal with deteriorating mental health and then look at self-harm questions, move to Christmas Island and pick up some of the issues that you've raised in the time that we have available, but perhaps to begin if I may, with the deteriorating and the evidence of deteriorating mental health in Australian detention centres. Now what I'm going to do is to use two graphs that are developed through you, through your services. One of them is a self-assessment by detainees as they come into the system and I know it's extremely difficult to understand these things, at least for the members of the public who are here given that you haven't had a chance to see them before, but I'm sure that Dr Parrish and staff will be aware of this. This is self-assessed by the asylum seekers themselves. And they come in, within 12 months they're assessing themselves at about 12% with what are described as severe forms of mental illness. In the first three months. But as time goes by, and I don't need to dwell on this too long, but by the time you get to 19 months plus, which of course applies to a very significant number of people, we're seeing a 41% self-analysis of being severely mentally ill. Now the question that I want to get to is the critical one for us and that is: What is the cause of this deteriorating mental health, self-assessed? We'll come to clinically assessed, if you like professionally assessed, in a moment, but for the moment why is there, there's such a significant leap from 12% to 42% peaking after 19 months?</p>
<p><b>Dr Parrish</b></p>	<p>If I could just explain this a little bit more. The take home message from this, and this is consistent with other data and studies that we've done and links</p>

	<p>into some of the comments that Dr Jureidini was mentioning earlier today, and these are the similar scoring systems that we use, is that on average we find approximately 30% of the detention health population has a mental health illness. That's pretty consistent across our stats and across our screening. Now that's predominantly for adults. I'll move on to children if I can in a moment, but the main reason for it is the detention health environment. This difficulty that people have with managing in the environment, and we find that this as you can see on this graph which is a little bit detailed, is that the incidence or the prevalence of this increase is the longer you stay in detention, and there's a clear link there.</p>
<b>President</b>	Thank you.
<b>Dr Parrish</b>	I can if you wish move on to children, because I know that's specifically what you'd like.
<b>President</b>	Yes, I think that obviously is of immediate interest to us.
<b>Dr Parrish</b>	<p>Yes, so the limitation of this study is that it's a self-reporting study and obviously using it in children in particularly challenging, and Dr Jureidini earlier this morning was mentioning a tool called the HoNOS, the Health Outcome of the Nation Objective Score and there is a subset of that which is called the HoNOSCA, which is for children and adolescents. So we have just recently introduced the HoNOSCA. So our HoNOS score, which is that this is a clinician rated tool, again consistent shows that as in adults we have about 30% of people with mental health issues and that is linked and increases with the length of the time in detention. We would assume that that is a similar picture in children and adolescents, but I would prefer not to assume and I would prefer to be working on the evidence. So we are now doing the HoNOSCA, which is a well-used tool around the world accepted by the World Health Organisation as a standard tool for assessing mental health in children and adolescents. In the discussions that we had with your staff last week we explained the tool and the fact that our clinicians are doing it now and have been doing it for the 780 or so children in detention and will complete it by the end of this month and we will have some detailed results which we will share with the Commission then.</p>
<b>President</b>	<p>Thank you very much, well that's very helpful because we are trying to get to the difference between you would expect in the general community which you put at about 30% and we see this at 42% rising with the length of time and we'll be very interested to hear the outcome of your research which I think will be very relevant for the purposes of this inquiry. But now I would like to move to the second slide, and this one is an important one because this has been</p>

	<p>conducted through the IHMS and it is one which is done by the clinicians, by the health care providers, by the medical profession. So that it has, if you like, that sort of credibility not a self-assessment but one that's done by a professional who understands the nature of these conditions, so obviously has an important level of credibility. Now again it's hard for you to perhaps fully see this or understand this in the short time but that heavy black line is the general community within these sorts of services but the lines that I would like you to have a look are all these other different coloured lines but most particularly the spike in the green that comes up with essentially cognitive and other physical illness and disability spikes for those in detention. But the one that's the most powerful set of statistics are those towards the end where you can see that the general public in relation to what you might, what are described as social items: problems with living conditions, problems with activities of daily life, problems with personal relationships and with occupation, lack of occupation and activities. These are the very, very worrying statistics in the sense that they are noticeably extremely high, as judged by clinicians for those people held in detention relative to the heavy black line which reflects the general public. I wonder perhaps Dr Parrish if you could tell us a little bit about what I'm trying to get to is why we have such a dramatic spike in those figures for people in detention.</p>
<p><b>Dr Parrish</b></p>	<p>Would it be ok if I stood up and just gave a little bit of a summary of this using, just pointing out? This is a complex slide and the various lines refer to how long you have been in the detention network. The heavy black line is community average. The HoNOS comprises of 12 particular questions which the clinician asks and then rates the answers, and answers can be can be linked between 0 and 4 [<i>inaudible</i>].</p>
<p><b>Ms Baldan</b></p>	<p>Can I just interrupt for one moment; the black line is not the well Australian community, is that right? It's the people who are engaged with mental health services so it's the people who are mentally unwell.</p>
<p><b>Dr Parrish</b></p>	<p>Thank you for pointing that out. So these are people who are already in the Australian community mental health system. Being looked after by community health care professionals. So when you do the scales you ask a number of questions maybe about behavioural items and you score it as a clinician between 0 and 4 and anything with 2 or above is felt to be clinically relevant so you feel there is an issue there. So as you see as you move along these are people in immigration detention depending upon how long they are staying in the system. Generally behavioural items, impairment items and symptoms items are below the lines of those people already being looked after in community health. A bit of a spike here around some of the symptoms of people are felling which would be maybe feeling depressed,</p>

	<p>unhappy anxious and then a particular spike here which goes above community mental health and heading up to the 2's which we find particularly significant which socialising and that's the [inaudible] that's being detained in the detention environment is where we see the closest links here and as you can see it increases the longer you stay in detention so that again ties in with our mental health data that shows this increase of issues as you stay in the system longer. So this is what we just do with children now, so this is the exactly the same tool but it has a child and adolescent flavour to it and again you should have that by the end of [inaudible]</p>
<b>President</b>	<p>Well thank you Dr Parrish and that research will be available for this inquiry and will give us the kind of technical clinical and creditable data that will underpin what recommendations that we make at the end of this reporting. So I'm sorry to take you through that level of detail but I think you can see that we need this level of accurate assessment in order to make recommendations to the government and so I'm very grateful explaining that a bit further, but now I would like to move away from that sort of level of detail to what is possibly proving to be the greatest matter of concern and that is the self-harm statistics that are emerging amongst the children, and we now know that there are 128 self-harm incidents over the last 14 months. Given that there are only 700 or only but there are 775 children in detention, this is a very high percentage of children who are engaged in these harmful activities. Can you tell us how these rates compare to the general Australian community?</p>
<b>Dr Parrish</b>	<p>In a word no, and I apologise for that right now but can I just again give a bit of an overall explanation</p>
<b>President</b>	<p>Yes, certainly</p>
<b>Dr Parrish</b>	<p>So although there are 780 children in detention now.</p>
<b>President</b>	<p>Self-harming</p>
<b>Dr Parrish</b>	<p>Yes, no I accept that, but so we are comparing the amount of self-harm against the number of children in the detention system. The numbers of children in the system have varied over the last 14 months and so what we would like to do and this takes quite a bit of data analysis that we have not got to yet, is to look at rates of self-harm compared to number of children in the system and I think that's an important thing to do because for instance in July of last year, 4,500 people arrived by boat on Christmas Island of which a significant number were children. So that will, it will alter the figures and again I would just like to make sure that we provide with accurate evidence</p>

	that we stand to, so we can look at those data and then to see how that compares with the Australian community.
<b>President</b>	Good thank you. So again that will be information that we will be able to use for the report that will be very useful, so I guess the next - you will answer that question more fully later?
<b>Dr Parrish</b>	We will answer that question when and again it relies on a little bit of data crunching because we have to know the number of people in each particular month and then how much self-harm was in each month so we can give you some accurate comparison.
<b>President</b>	But I think we could even in the absence of that more detailed response, we can still say that over the last 15 months to have 128 children self-harming appears to be a very significant and worrying figure. Would you agree with that?
<b>Dr Parrish</b>	If that's the number then it does appear to be a worrying figure but again I would like to look at it compared to community average because that will be important but personally President one episode of self-harm is of concern to us.
<b>President</b>	Thank you well I think that's very helpful. Can I ask the question, why do you not know the rates of self-harm?
<b>Dr Parrish</b>	Because of the difficulty in pulling it out of some of our systems. And we have it but I want to make absolutely sure that you have the accurate information. So there are a number of reasons for it but one of the things is we have moved from one health information system to a new health information system in February this year. That has allowed us actually to provide much accurate data from February onwards. Going back is harder for us and we want to make sure that we absolutely can get it.
<b>President</b>	I can understand what you are saying but if you are right in saying one child self-harming is worrying, I would have thought that with these mounting numbers you've been aware of this situation for quite a long time. Why, this far into the inquiry, are you still not able to tell us what these rates of self-harm are? It's the same answer...?
<b>Dr Parrish</b>	Well it's the rates, yes, I want to make absolutely sure that we have the rates compared to the numbers of children in detention. We discuss these with the Department on a regular basis, we provide a quarterly set of data up to the Department based on a number of health figures from mental health and primary health care issues as well.

<b>Dr Gadd</b>	It is also important to say that the incidents of self-harm themselves are appropriately managed on each occasion that we do discover them.
<b>President</b>	Good, well that leads me to my question and that is when you are aware of an incident of self-harm that is reported, what do you do?
<b>Dr Parrish</b>	Maybe I could take that first and then I might actually ask Dr Gadd to comment here as Dr Gadd has spent some time with us on Christmas Island and at a number of our other Centres. We would prefer to prevent self-harm. And if I was to step back to how we start and how we run mental health overall, we screen everybody with a standard mental health screening tool on regular times throughout the system. From those we can pick up people of whom we have concern and we can then provide a number of programs to try to help them. We very much do this on an outreach basis with group work as well as individual work across all of our Centres and those that are of particular concern will be escalated to see a general practitioner and if necessary to see a psychiatrist and we have psychiatrists either on site or visiting or we use the local Psychiatry Service both adults and child and adolescent psychiatrists wherever we are. We will put in place a program to manage those individuals and as part of that we have this Psychological Support Program which was mentioned by one of our colleagues earlier, I think by Ms. Pamela Curr. It would I think be worthwhile talking a little bit about PSP because there is a little bit of confusion about what PSP is and how it works. We had a slide, I wonder if we could just show the slide of PSP and then I am going to ask...
<b>President</b>	PSP being Psychological Support Program that I believe Ms Curr described essentially as a suicide watch program.
<b>Dr Parrish</b>	Well, it's a little bit more than a suicide watch program.
<b>President</b>	I repeat her language because that was the evidence she gave.
<b>Dr Parrish</b>	Sure, but I would say it's more than a suicide watch program and I am going to ask Mr Gilbert to talk about this because Mr Gilbert has been with us for a considerable amount of time, was part of and involved when we introduced this program and it came as part of our work with the Department to look at how we manage people with mental health issues.
<b>Mr Gilbert</b>	Yes, I will start maybe and hopefully others can chip in. Just by my background I'm not a clinician myself, I'm the Chief Operating Officer as I was introduced previously so I have worked in the detention health setting providing health services for almost 10 years now. So I do have a bit of

background to this as Dr Parrish said. So the Psychological Support Program was a policy that was instituted in late 2009 and it was done so on the advice of the Independent Advisory Panel then called DeHAG which then moved to IHAG post that. We worked very closely with members of that Health Advisory Group and the torture and trauma service through Paris Aristotle's forum to design this program, educate it and implement it. It's designed in a way to manage risk and I think the risks of detention particularly over a longer period of time are well understood and without going into the detail around that, this program is there to understand that risk and manage that risk in a clinically appropriate manner. So when we talk about psychological support program, immediately anyone who enters into immigration detention is considered to be a participant in that program and it essentially provides an access to our mental health services. It also contains a routine screening service, so anyone who enters into immigration detention is assessed using a range of instruments that are also independently recommended previously through the DeHAG and then IHAG Group, and then at subsequent junctures of time to assess any degradation in people's mental state. So there is a baseline assessment process there that is clinically led and there are several forums that take place on each location, each facility and that involves multiple stakeholders. So it's not only IHMS as the medical professionals it would also be Serco as in their role as providing security and support services but also Maximus in their roles the welfare provider particularly for children in those locations where they do provide that service. So that is a forum that meets daily and its essentially an environment that allows all stakeholders to present any information that they might perceive to present an individual detainee or client at risk and then that is effectively case managed in that forum and appropriate action and care plans and actions taken out of those forums and actioned. We talk a little bit about SME there, which is Supportive Management and Engagement. Now this is effectively a risk-rated response to a level of risk that an individual presents with. So we talk about ongoing SME there, moderate SME and high imminent. When Ms Curr talked about the suicide watch previously, it is probably more the high imminent element of this program that would relate to where someone does require a heightened level of observation to manage that risk and that would particularly be where we believe there will be a suicide risk. But underneath that there are different forms of observations and programs in place to support an individual. It doesn't necessarily mean that an officer or a guard or a clinician is in direct attendance of that individual, it might be that we develop a care plan around that individual to manage that risk most appropriately. It might not be appropriate for example to have someone under a 24 hour watch program because it might present them more anxieties and not necessarily help the situation. So this whole process is

	<p>clinically-led, so when someone is determined to be on a particular level of watch or particular program to support that risk, those decisions are made by a clinician. And equally when there are decisions made to escalate or de-escalate someone within that program, which is clinician-led as well. We've talked, just to the side there, about the Serco Keep Safe Program. This is effectively a mechanism that allows the Serco officers the ability to make decisions regarding the psychological support program outside of hours when IHMS staff might not necessarily be on site.</p>
<b>President</b>	<p>Well I wonder if I could just stop you there. It's very helpful to know what this process is in place and encouraging. One of the things that we are really trying to come to grips with in this inquiry, is what appears to be, on the evidence, a disconnect between the systems, the policies, contracts and what is actually happening on the ground. The evidence suggests that we have apparently very high rates of self-harm actually occurring in relation to these children. So one inevitable question I must ask is, why is this system not actually proving to be effective in preventing these acts or incidents of self-harm that are being reported? If this is effective, if is this a clinically proven and led and driven process, why is it manifestly not having an impact and that is what I am trying to get to, what is the impact on the children that are being held there?</p>
<b>Dr Parrish</b>	<p>Sure, maybe I can answer that partially President, and then I can ask Dr Gadd to give some comment from his experience. Any system and process that we put in place is put in with the recommendations of various expert bodies of which this was with the Detention Health Advisory Group, and complies with best practice in management of mental health issues.</p>
<b>President</b>	<p>Again, I can accept that as a policy but I want to know is what's actually happening?</p>
<b>Dr Parrish</b>	<p>Yeah well happening every day at every site. No system is fool-proof and no system is perfect and so whenever we have a case of self-harm, we will always report it and we will look into and see if there is anything particular that we could have done differently to prevent that happening. So it comes back to the rates of self-harm and I do think any self-harm is a terrible thing and we work very hard to try to prevent it. So each time there is one if there's something we could've done differently that we can learn from that means that we can prevent something else happening in the future. I would like Dr Gadd to make a couple of comments if he could from his time on Christmas Island about this if that would be okay?</p>
<b>President</b>	<p>Please.</p>

<b>Dr Gadd</b>	So answering I think you asked questions just about the process, so if a child is identified as having...
<b>President</b>	Can I interrupt you? Sorry because you've only just started to speak. I'm not really interested in process as such. I am interested in what the impact is on the children.
<b>Dr Gadd</b>	Well what I was going to say is this is the way it is done also then it's dependent on why the reason of why of the self-harm.
<b>President</b>	Yes.
<b>Dr Gadd</b>	And is this self-harm which is separate to suicide or to a suicide attempt? So that's the first step in any assessment from my perspective. Is this self-harm or is this a suicide attempt? And knowing there is a continuum between in some cases between self-harming and suicide attempts and in other cases self-harm is not related to suicide in any way. So that's what I wanted to say. And then as to reasons why, its I've spent 6 weeks on Christmas Island and had, I was in a supervisory role as a GP. So I haven't got fully abreast of what occurs on Christmas Island in terms of all the information. But a lot of the information like as you saw those peaks, my personal opinion is a lot of it is based on what's been discussed previously is in relation to is about hope and helplessness in that children are generally quite resilient and they need, if they've got really good parenting and hope they can generally survive in most environments. But if you take those things away from children they don't, they have, they do suffer.
<b>President</b>	Well can you elaborate a little on that because its rational sense what you're saying and yours is obviously based on experience, but when they are held in detention, how quickly do they work out that they have very little hope or all that they can expect is they will go to another remote island where they may or may not be assessed for the refugee claim?
<b>Dr Gadd</b>	I can't comment to your precise question because I haven't had spent a long enough time observing that.
<b>President</b>	No.
<b>Dr Gadd</b>	But the I've got a so my background is as an Indigenous doctor and I've spent the first half of my career in doing indigenous health and the second half of my career doing emergency medicine. So that's where my experience comes from, is dealing with Indigenous health and then also dealing with the emergency medicine. And the part of this that's relevant to this is parents who bring their children and who have been self-harming or children and

	<p>adults brought in by the police with self-harming or suicidal ideation. So that's where my experience comes from. And the experience that I've, in some ways there's some similarities between indigenous health and the detention environment. In terms of hopelessness and helplessness and also in terms of themes like education. So there's lots of things that I've seen that have come across as very seem to be the same themes that are a problem in Indigenous health such as education, that children there's not that priority of education for and the need for education that families have seen and literacy and numeracy skills in children. So they're very common themes that I've seen between the detention environment and the Indigenous health environment.</p>
<b>President</b>	<p>Well that's very helpful because you're really helping us to understand again that it's the circumstances of detention and particularly that sense of helplessness and sense of no future that is adding to or a direct cause of their self-harm and/or suicide intentions. It's beyond your experience, I know but one of the things of course that has been concerning us has been the lack of education for children on Christmas Island and I imagine that that is a part of the environment that has exacerbated the children's perception of helplessness.</p>
<b>Mr Gilbert</b>	<p>Yes. I would agree with that and so as part of the wish to provide education because we think that is a significant helper, we have worked very closely with the Department and education providers particularly on Christmas Island. So we've provided some medical information and advice for the provision of health care. We've made sure that all the children are vaccinated so that they can go to school and we've been collaborating with the education provider so when the school does start there, I believe its later on this month, we think that will have a significant affect, a positive effect on the mental health of many of these children.</p>
<b>President</b>	<p>Well that's very helpful. The next question is really perhaps for Dr Parrish and that is, do you have any longitudinal data or studies, given the very wide experience that IHMS has on detention and on detention of children, do you have any evidence about the mental health impacts on children of detention and prolonged detention?</p>
<b>Dr Parrish</b>	<p>We have it in a I would say a not particularly evidence-based piece of data because the tools that we've been using, as I mentioned before, were more structured for the adult population than the child population and as we experience increasing numbers of children into the system and that's a relatively new thing, we have changed our model of care to look after those children but that's why we put in place the HoNOSCA. So what we will see</p>

	with the HoNOSCA - it will give us a point in time information about the mental health of those children. We will do that every three months, so we can then track that as we are able to do with the adults in the slide that you saw earlier.
<b>President</b>	I think one of the points that I'm trying to understand a little bit better is, as the research that is available is fairly clear in saying that the longer children are held in detention the higher the impact on their mental health. Why do you not have sort of coherent long term, longitudinal data on these questions when you've really been aware of it as a medical research issue for decades? And we, as you know, this is the second time around for Australia, we know what happened 10-12 years ago.
<b>Dr Parrish</b>	Yes. Because we haven't been using the screening tools specific of children until recently and we've discussed doing that and introducing those and making sure that we can do that. If I could go back five years I think I would much prefer to have those screening tools and be able to track those things. But I think we will be in a better place to do that.
<b>President</b>	In the future.
<b>Dr Parrish</b>	Given that though, I think that there is the aspect of the increasing mental health issues as time in detention says and then there is the individual management of those cases. And what we do have is a good understanding of the individual cases and how we manage those and the particular treatment plans and management plans that those children and adults need. And we manage those on a collaborative basis between us and other stakeholders, because it is a collaborative approach to managing many of these mentally unwell people as well as the physically unwell people also.
<b>President</b>	I'd like now to move to Christmas Island because that is the area where, on our evidence and our own observations, health services appear to be ... where there's a greatest disconnect or failure by reference or by comparison to the Australian detention centres situation so I will concentrate on that.
<b>Dr Parrish</b>	Yes.
<b>President</b>	You've mentioned yourself the very poor health status of children in relation to particularly eye-wear, their access to opticians and to replacement glasses. I won't go into the wider questions because we have dealt with them in other context but I want to come to this question that we see over and over and over again, is that children are not being given the eye, ear or dental services that they should have. And we have many, many examples but one that I think perhaps has the greatest resonance for us is that a seven year old child

	<p>whose glasses were broken either coming to or on Christmas Island and she has been 11 months without replacement glasses. Now, were she to have had the opportunity for an education on Christmas Island, which she doesn't, one can easily imagine how difficult it would be for her to function at all in a schooling environment. She's obviously not at school but she's nonetheless trying to, in a very important part of her life, or phase of her life, to try to develop and to engage. But she hasn't got any glasses. That's an extreme case possibly but I want to know why it's happening, why there seems to be such a particular problem with getting eye attention. I think all Australians know that it takes you a couple of days. Go down to your shopping centre and you can get some glasses in no time at all. Christmas Island is only 4 hours flight away from Perth. Why is this proving to be so difficult?</p>
<b>Dr Parrish</b>	<p>Yes, thanks for that. So just that particular case because I have taken a personal interest in this case and I think we could have done better there. The child arrived I think in August of last year. In fact, was given a standard chemist's magnifiers in earlier of this year and was seen by our optometrist last month or the month before and had some glasses lost.</p>
<b>President</b>	<p>Can I stop you there? I think chemists' glasses are only useful if you've got exactly the same condition in both eyes and I understand that this child has a lazy eye, which is quite different from the other and if it's not treated there is a risk that she will ... they will lose the sight of that eye. Is that true?</p>
<b>Dr Parrish</b>	<p>That's ... she has Amblyopia and that's true and she has an appointment with an ophthalmologist scheduled at some time. I'm not quite sure exactly ....</p>
<b>President</b>	<p>Why does this take ... I'm sorry to emphasise one case but to understand the whole we have to understand some of these cases. How can it possibly take so long to give a child with a condition that you have identified, so long to get the attention that she needs?</p>
<b>Dr Parrish</b>	<p>Can I just give you an overview of how we manage things in general and then focus on this particular child? So an optometrist for the Christmas Island community and an optometrist visits every 12 months and we ...</p>
<b>President</b>	<p>One visit, every 12 months?</p>
<b>Dr Parrish</b>	<p>Hmm. For the Christmas Island community at large. Yes. But for anybody in the immigration detention system on Christmas Island who has a medical requirement which we cannot manage within the centre or the centres on the island, we have a number of options for managing that. We will provide visiting specialists and we have a dentist that visits every month and has done so for many, many years and in fact all of our children are up-to-date</p>

	<p>with their dental checks. That doesn't mean that they don't need further work but they are up-to-date and they are in no pain and we have a plan to manage them. We have visiting psychiatrists, we have other visiting specialists. And then for those other conditions which cannot be brought to the Island or managed on the Island, we arrange for them to be managed in the public health system in Australia and as I mentioned in my opening statement, we use some guidelines from West Australian Health that give an idea around priorities of access for different conditions. And we allocate patients depending upon the urgency of their need and those guidelines for care and then we manage that and we track that. So we try to make sure that people don't go outside those particular issues. So in this case of this particular child, she has been referred to the Australian mainland and the public health system has given her an appointment later on this year. And that's using their access criteria. So they ... we will refer a patient and ask for an appointment. They will review and give an appointment in the time that they think is appropriate for this to be seen, which may actually be a little bit outside our guidelines sometimes because they're guidelines rather than hard and fast rules and so she will be seen. So, for this case, I agree with you President, we could have done that better. For other cases, every child that is on the waiting list on Christmas Island to be seen, is within the time that we would wish them to be seen off Island. And there are, I think of last week, we mentioned this to your team, 74 children who have been on Christmas Island who are on the mainland having a variety of healthcare issues managed throughout the mainland network. So I think this case is a good example. We could have done better there, I quite agree and we have an optometrist that's visits Christmas Island and will come more regularly than once a year to make sure that we manage all of those optometry issues.</p>
<b>President</b>	<p>Well I'd like now to move to a particular problem and that is that we're receiving advice from health experts in Australia that there is a high prevalence of latent tuberculosis infection of between 20% to 55% among refugee and asylum seeker cohorts, and that risk is higher in young children. That is the advice that we are receiving. What I'd like to know is does IHMS carry out routine screening of children under 11 for tuberculosis, including those children who are being so rapidly transferred to offshore processing centres in Nauru?</p>
<b>Dr Parrish</b>	<p>And the answer is that we don't carry out routine children. And the advice that we have received from eminent TB authorities is that we should not ... do not need to carry out screening for children on tuberculosis.</p>
<b>President</b>	<p>And why is that?</p>

<p><b>Dr Parrish</b></p>	<p>That's the advice we've had and it's a poor pick-up rate ... it's a poor way to pick up tuberculosis. We do screen those children where they have been in contact or they may have a parent with tuberculosis and so at the moment in the immigration detention system within Australia we have two children with active tuberculosis and we have nine ... sorry, 14 latent tuberculosis and we manage those. There is a lot of discussion about the best way to screen and to manage tuberculosis and we rely very much on expertise from the Department whose Chief Medical Officer is a world renown expert on tuberculosis and we work with them on the screening that we need to provide. For children being transferred to Nauru, the understanding is that we will not send children with tuberculosis and therefore what we will do is we will screen them with a test called a Tuberculin skin test and then a BCG, a vaccination for those.</p>
<p><b>President</b></p>	<p>Well, I'd like then to follow up on that question of children who are transferred to Nauru from Christmas Island. Do you recommend then, and it appears from the answer to the last question that you there will be occasions when you recommend that a child not be transferred. Beyond the tuberculosis cases are there other cases where you would make the judgement or your medical officers would make a judgement that it's not appropriate to transfer that child to Nauru?</p>
<p><b>Dr Parrish</b></p>	<p>In simple terms yes, there are a number of different criteria that we use and I might just hand over to Dr Gadd who has been involved in this as to give you some more detail as to how we assess everybody that arrives on Christmas Island whether it be an adult or a child and then assess their fitness for transfer to Nauru.</p>
<p><b>Dr Gadd</b></p>	<p>Okay, so the area medical director gets a list of the proposed transfers to the OPC which at the moment is just Nauru. And my job effectively is to rate them in that's a from their health perspective and I give a number basically 1, 2, 3 or 4. One means that they've got no outstanding medical conditions, they have a medical condition that can be managed in a remote area and I will just give a little bit of background to that. What I basically want to know is, is the medical condition they've got consistent with the community standard in Australia of living in a remote area? So if the specialist at the Children's' Hospital in Perth say this child should not be in a remote area, I then recommend, I basically say that child is not fit to travel and is in fact probably not fit for Christmas Island and I recommend that through the health liaison officer through the Department of Immigration and Border Protection that the child should be actually go to community detention or some other form of detention in a capital city close to a tertiary children's' hospital. The</p>

	<p>next step is, so do they have any outstanding medical conditions or outstanding medical tests or do they have an appointment with a specialist within the next 6 weeks. If the answer to that is all no then that is categorised 1 is fit to travel. The next step is category 2 which is temporarily not fit to travel and it's the group of people who have medical who have 30 week greater than 30 weeks gestation, have a medical condition that at the moment is for investigation, have outstanding significant blood tests that are or pathology tests that we're awaiting results for, and then they are given a 2. Three (3) are the blood borne illnesses so hepatitis B, C, HIV and people with tuberculosis and that they are given a category 3. So they may actually other than those conditions they have no other problems and then category 4 if not fit to travel. So for instance, the child who has a medical condition that is not compatible with Nauru so they need increased medical treatment, that child is given a 4. So not fit to travel and I would also advocate that as I said there was two children that I was there that had conditions were asked a question the pragmatic question to the consultant saying "would you recommend this child if they were not in a detention environment, if they lived in Broome for instance, they lived in Broome would you recommend that children that the parents move to a capital city?" Because that's what I want to know. Is can they be managed in a small peripheral hospital with the care that can be provided in small peripheral hospital or do they need a tertiary referral or even a quaternary referral system and if they answer is they need a tertiary or quaternary referral system for me is a very easy decision and they need to go that area.</p>
<b>President</b>	<p>Well thank you very much because one of the things that we wanted to learn in this inquiry is how the decisions are made in relation to particular children. Why some go to Nauru and others do not or some come to Darwin and return to Christmas Island and are held. But there are several follow up questions. One is, when you make a recommendation that a child not go to Nauru, is not fit to travel to Nauru, is that advice accepted by the Department?</p>
<b>Dr Gadd</b>	<p>In my experience, yes.</p>
<b>President</b>	<p>Good. Thank you. We're hearing very negative evidence about the conditions in Nauru. Why would you imagine that its ever appropriate to send a child to Nauru in terms of the their physical and mental conditions in which they are likely to be placed once they get there?</p>
<b>Dr Gadd</b>	<p>The question that I'm, like in terms of my personal politics.</p>
<b>President</b>	<p>No we're not going, we don't need to...</p>

<b>Dr Gadd</b>	I'm just saying my personal politics are I'm a doctor and the question I'm asked is about their health care needs.
<b>President</b>	Exactly and that's the question I'm asking you.
<b>Dr Gadd</b>	So the health care they provide, that is given to them, is would be an equivalent standard to a remote area in Australia.
<b>President</b>	Uhuh.
<b>Dr Gadd</b>	And that's the question I'm asked. Is this child fit to be in a remote area? And that's the level of health care that IHMS provides and in fact they probably provide a slightly more high level than a remote area.
<b>President</b>	Are you confident then that they quality of health care available on Nauru is comparable to a remote centre in Australia?
<b>Dr Gadd</b>	Having never worked in Nauru I cannot make a personal...
<b>President</b>	No, I understand it's very difficult.
<b>Dr Gadd</b>	But the remote settings that I've worked with IHMS, they have far exceeded the remote setting in some of the remote communities that I've worked in.
<b>President</b>	Well that's a very important observation particularly given your background. Thank you very much indeed. I do, however, want to make raise one particular problem or issue and this is the father of five children from Syria. He's been transferred to Nauru despite the fact that he can't walk for very long distances, he's got a hernia. But the critical point is that his eight year old son was seeing a mental health team on Christmas Island every fortnight. He was within this system in other words but nonetheless and he was taking medication with bed wetting and all those symptoms that a disturbed child are likely to evince. Nonetheless this family as a whole, including the child, were assessed by IHMS as fit to go to Nauru. Now I don't ask you particularly about that but perhaps I can return to Dr Parish. How does a case like that ever get assessed as appropriate to send to Nauru?
<b>Dr Parrish</b>	I would like to separately look at the details of the case President, because it's hard commenting on it here without having the full facts.
<b>President</b>	Well that's fair enough but it's very worrying that the system.
<b>Dr Parrish</b>	Yes but maybe I could just make a couple of points. So you mentioned earlier that if we assess that a child should not transfer offshore because of a health care issue they wouldn't sent that's true and therefore, their family

	won't be sent. And similarly if a parent is medically unfit then the family won't be sent either. We although I do understand that the remit of this inquiry does not cover offshore I can give you-
<b>President</b>	That's not our view of our jurisdiction.
<b>Dr Parrish</b>	That's fine we can agree to disagree on that. But I can, maybe I can help you by giving you a little bit more information to that which Dr Gadd gave you as he hasn't been to Nauru but I go there regularly. And in fact the health care that we provide there is similar to that which we provide at all of our remote sites if not actually to a slightly higher level because of our awareness of stuff there, and that includes mental health professionals to the same extent that we provide here in Australia with visiting psychiatrists, both adult and child and adolescent, and telehealth services. So and we have a single standard electronic health record which means that if you are anywhere in our system you can see the results and see what's happening with this particular individual. So for that, to go back to this particular the simple answer is I'd really like to look at this and maybe discuss it with your team separately. There may be other reasons why this has happened. There may be other things in the pipeline now that I'm unaware of or may not be aware of which may be affecting that.
<b>President</b>	Okay. Well one final question and it does derive from what you've just said to me, and that is can you give me your view as to the general physical and mental condition of those people who are on Nauru, but who are transferred back to Australia typically I think to Darwin, but not necessarily. What is your view of their health when they're being transferred back?
<b>Dr Parrish</b>	Those are the ones being transferred for healthcare needs, I think is the ones.
<b>President</b>	Yes.
<b>Dr Parrish</b>	So just to explain this. We treat all three islands essentially as the same and we manage them in same way, so the way that I've described on management of healthcare on Christmas Island applies elsewhere. So if an individual has a healthcare requirement which we cannot manage on the island we will recommend they are transferred elsewhere. They don't, they may not necessarily go to Darwin and this is because of where the Department has accommodation. So we will make a recommendation based on the medical needs for this particular individual, and sometimes there's some very specific medical needs which may only be managed in capital cities and actually that may not include Darwin because, for instance, Darwin

	<p>does not have a local cardio thoracic team or a neurosurgical team. So we would recommend then that patients move somewhere else like Sydney, Melbourne or Brisbane, or a similar large place. So we will put that recommendation up and that will be accepted and we will then move people there. So we are, on every day of the week, managing a wide variety of both medical issues and mental health issues, either on-site with the team that we have there or transferring them to other parts of Australia. That happens from Christmas Island. It actually happens on the mainland network as well if we find that we have a particular condition that we can't manage, for instance, on-site and Darwin is a good example of that. We will put a recommendation that it's managed elsewhere in Australia.</p>
<b>President</b>	<p>Our observation has been that quite a number of mothers and babies, or mothers about to give birth, are being brought from Nauru to Australia and, as I say, typically Darwin but not necessarily depending on the advice that the clinicians are giving. Why are these people being brought back? What is the reason for it? In other words, if the standard is remote care, I assume that the person in remote parts of Australia is not always brought to regional centres to give birth, or maybe they are.</p>
<b>Dr Gadd</b>	<p>They actually are. They are. In most communities, the most remote, there's very few remote settings that I'm aware of will actually deliver babies.</p>
<b>President</b>	<p>Right, so this is typical practice for a remote population.</p>
<b>Dr Gadd</b>	<p>To the communities that I'm most familiar with, they would be removed to the next largest town that has, that can give, safe birthing facilities. If they are an at risk pregnancy they would then go to a much larger hospital. So no, there's very few remote communities.. Christmas Island, for instance, does not do deliveries. They'll only do mothers who, for whatever reason, couldn't wait but they actually transfer their pregnant women at 36 weeks to Perth. So there are actually no deliveries, no elective deliveries on Christmas Island. and that's the policy of the Health Service.</p>
<b>Dr Parrish</b>	<p>So we run a similar system as Dr Gadd has described, so Christmas Island is a good example of this. That actually applies to other islands should you wish to think about...</p>
<b>President</b>	<p>Yes, but we're obviously interested in Christmas and Nauru because that's where the children are.</p>
<b>Dr Parrish</b>	<p>Yeah, so Christmas Island, we will assess the risk of each lady's pregnancy,</p>

	<p>and if they are particularly high risk we will move them off the island early. If we feel that they are of a normal risk pregnancy they would be managed in line with anybody else on Christmas Island. So we have a visiting ultrasonographer every month that can do all of the antenatal scans. We have a visiting obstetrician and we have a midwife on our staff there, so we manage it as a standard antenatal care anywhere in Australia and we will then transfer that person to the mainland for delivery. If it's a high risk case, and we're particularly worried about a pre-term birth or some other issue, we will move them off sooner and we do that on both of the islands where we have pregnant women.</p>
<p><b>President</b></p>	<p>Now moving then to the mental health of these women and their families. One of the things that we've been observing, of course, again typically in Darwin, is where they've been brought for the birth of a child from Christmas Island or Nauru, but they then live in daily fear that they are going to be returned and will be returned under policy to either Christmas Island or to Nauru. Do you have special procedures for managing that growing fear, depression and anxiety about what is going to happen to them? The difficulty being that while it seems a very humane and appropriate process to bring them to Australia for the birth of a child, I think anybody would see that as an important thing to do, there's a sort of bitter sweetness to it because they then see what the conditions are like in Australia and they then know that having had a few weeks in the care of an Australian environment they have to go back to those conditions. How are you managing that?</p>
<p><b>Dr Parrish</b></p>	<p>Yes, thanks. So we manage it as other mental health issues that we manage in our network, with a variety of outreach programmes and specific targeted programmes for families and for young parents. And as part of that we will discuss with them, you know, how they manage their baby because some of these people this is their first child and they would not have, let's say the large family that they might have in their own home country as we would have. So we will help them with that, we have specific targeted parenting sessions. Sometimes which we share with the local obstetric unit and a local hospital and antenatal unit, and community child health and like so many things, our patients spread across the spectrum. There are those who actually have no problem with the birth and manage remarkably well and there are those at the other end, as I think Ms Curr described, with you know significant post-natal depression, some of whom need specific treatment by a mental health team, maybe by a GP, maybe with medication, maybe with a consultant psychiatrist visiting, some who may need admission to hospital, and we will manage those as we do for everybody else and if the recommendation is that they should be in hospital, they will move to hospital</p>

	and we ...
<b>President</b>	So you are well aware of this almost systemic problem that Sister Brigid and Pamela Curr have been identifying?
<b>Dr Parrish</b>	Oh very much so, and one of the things that we have done, or if we haven't done we certainly will do, is make sure that we provide you and your team with a list of the various programmes that we put in place. Not just for antenatal and post-natal care, but for all of the other outreach mental healthcare programmes that we provide, where we spend a lot of time teaching what we would call, well our mental health team would call, resilience and hopefulness and wellness. It sounds a little bit corny, but it actually works.
<b>President</b>	But it's key to helping mental health., key to mental health
<b>Dr Parrish</b>	Oh very key. Very key indeed, absolutely. And so for those who are, you know, we feel are just, are not fit then we will recommend that and that's acceptable.
<b>President</b>	Well my last question takes us from that level of detail to the much bigger picture, and the bigger picture that we're receiving is that most asylum seekers and refugees feel that they have adequate to good services on the Australian mainland and there's no doubt that the conditions in the detention centres that we've visited, seem good, with some problems but that are being identified and addressed. Where the huge gulf appears to be lies with the delivery of services in Christmas Island, and although we have less direct evidence, of course on Nauru. What are you doing to address this gulf between the quality of services that appear to be, on the evidence we're receiving thus far, being delivered in Australia, relative to the quality of the service delivered on those two islands?
<b>Dr Parrish</b>	I actually don't believe there is a difference in the quality of care being provided. I appreciate that you are getting separate information and we have spent a lot of time with your team discussing this, but I have particularly spoken with our team on Christmas Island and on Nauru about this. And if I look at the service for instance that we provide on Christmas Island and if we look at it from a child adolescent parenting perspective as such, we run it very much like a community health service and Dr Gadd will provide some further details in a moment but we have a very open door access so parents can come in to see our health care professionals. We make sure we are providing..

<b>President</b>	But why are we receiving evidence that directly contradicts what you are saying?
<b>Dr Parrish</b>	I can't explain, but again I am very happy to look at particular issues and try to understand where there has been a gap there, because that is not what I see. Sure, any healthcare system President will have some gaps that we would wish to improve on. I think the optometry is a good example of that. We are always reviewing what's happening and trying to improve that, but I think the fact that all of our children on Christmas Island are up to date with their well-baby and their child developmental checks is a good thing, the fact that they are almost all up to date vaccinations is a good thing, the fact that we are working closely with the schooling is a good thing, the fact that we run this community type approach with a lot of [inaudible]
<b>President</b>	Well there isn't any schooling on Christmas Island.
<b>Dr Parrish</b>	There will be soon.
<b>President</b>	Well that is another matter.
<b>Dr Parrish</b>	I think that all helps but I am delighted to look at particular examples, in fact we have looked at some examples with your team and I'm very keen to continue to do that.
<b>President</b>	Well there are many, many examples and I can't take up this public inquiry time to discuss them. We have got to understand better why there is such a different perception that we are receiving from the one that you are providing to us. The typical stories we receive is in fact this man I have already described to you with the hernia, turns up to hospital twice asking for an operation and is turned away twice. There must be an explanation for this evidence, and my experience is that they are telling the truth. So there is something going wrong. And the other is the one you are very well familiar with and that is we are constantly told on Christmas Island, they go to see the medical professional and they are told take a Panadol and go away. Now this is common language and common responses and we have to ask you why there is this breakdown in perception of the quality of services, and I think it is something we need to explore perhaps in another context but we do need to take it further.
<b>Dr Parrish</b>	Could I make a couple of suggestions?
<b>President</b>	Yes.

<b>Dr Parrish</b>	And first I am going to ask Dr Gadd to come in because he has spent a lot of time on Christmas Island but I wonder whether we might all visit Christmas Island again. Because I think that might be a useful thing to do.
<b>President</b>	Well I am very happy to go, especially as I notice every time I go, things improve, temporarily.
<b>Dr Parrish</b>	<i>[Laughing]</i>
<b>President</b>	So if that improves things I am happy to go there any number of times.
<b>Dr Parrish</b>	I would be delighted if we could go again, because I am as keen as you to look at this slight -
<b>President</b>	We can look at it together.
<b>Dr Parrish</b>	This slight dissimilarity here that we hear.
<b>President</b>	There is a disconnect between the two.
<b>Dr Parrish</b>	Yes and I see a lot of the individual cases that we have been discussing with your team and there is a difference there when we look through sometimes, but if I talk to Dr Gadd maybe you could.
<b>President</b>	I think maybe we could give you the last word and just trying to wrap this up.
<b>Dr Gadd</b>	I think one of the problems I find actually with the provision of services on Christmas Island is the fact that it is actually a remote location and we cannot compare a health service that is in Melbourne to a health service that is on Christmas Island because we are in a remote location. So for instance, a so if someone has a heart attack on Christmas Island, their time to a retrieval to get to Perth could take greater than 12 to 24 hours. That's a normal citizen who is there. Purely because we are reliant on the Royal Flying Doctor Service and they've got only a limited amount of resources and they cover the largest state in Australia. So when we come from that perspective we have to understand that people who are in remote areas have a access to tertiary referral level of care at a much lower rate. So that's for all comers. So that's the big problem with Christmas Island is that it's a remote setting and you cannot provide tertiary level services. What you can provide is good community care and acute, emergency care which is what is provided,. So Construction Camp, they have two systems, they have an appointment based system with a drop in system as well. So no child when I was there and part of my daily routine was I would actually always finish at the Construction Camp and check on how things were going and to ensure that there was

	<p>always, we had enough resources to handle the fact that on numbers there is not that many people in Construction Camp but what we do have is 200-odd children who have a completely different level of need. And I would always ensure that there were two doctors, we had medical care that was at least the equivalent of the North West Point facility. So that was my one statement.</p>
<b>President</b>	<p>But is there not a huge difference between remote communities in Australia and a remote community as defined by you on Christmas Island where they are in essentially prison camps behind wire, unable to move and with this great desperation and lack of a future because of the nature of our assessment process; are they not quite different circumstances?</p>
<b>Dr Gadd</b>	<p>They are different in terms of the hopelessness, helplessness and the actual policies and the mental health staff. In terms of health care provision, Christmas Island health care provision that IHMS provides is as good as or better than a lot of the remote communities I have worked in. There is much more mental health workers for instance and nursing staff and a population of 1,200 people on Christmas Island. If they were in a community or a remote Aboriginal community in Australia they would not have seven doctors.</p>
<b>President</b>	<p>Well I will leave you with that last word because there is a very powerful political point for much broader purposes. So we've greatly benefitted from your experience of working in remote communities I think it is very helpful in putting this into perspective. Thank you Dr Parrish, I think you've really made an effort to provide detailed responses to the matters that have been concerned with us or concerned us and its clearly obviously of benefit for our relationship to continue so that we can get to the bottom of some of these evidentiary disconnects that appear to be emerging, so thank you all very much indeed for your evidence. Thank you very much. I'm sorry we have kept our next witnesses waiting for quite a long time, thank you, we now move to the swearing in.</p>