**The appropriateness of facilities in which children are detained**

* **How would you describe the immigration detention facility? Are there fences, checkpoints and mechanisms that limit the movement of children?**

Detention centres and most alternative places of detention (APOD) have fences, checkpoints, and mechanisms that limit the movement of children and young people. The areas inside the compounds are generally free to move around in. Detention security monitors the in/out flow of people through the front gates and there are security checkpoints around the perimeters. On Christmas Island, there is limited space and resources to engage children in play, education, and exploration in open spaces. The family camps resemble smaller-scale prison-like environments. I have witnessed how the lack of freedom and constant surveillance becomes increasingly confusing and intimidating for children and young people over time in detention. It is my observation that children and young people in detention live within an environment that is controlled, restrictive and regulated.

* **Is there access to a natural environment for children?**

There is limited access to natural environments for children and young people across detention centres. The centres lack trees and gardens. Some centres have designated play areas for children. I saw one small playground at Darwin APOD that consisted of a slide, climbing apparatus, and swings. This was generally free to access at any time and I often observed children playing in the early mornings or late afternoons when the temperature was slightly cooler. There was a shaded area near the playground. On Christmas Island, there were very limited or no play areas of free and easy access for children. Children across centres presented as bored and lonely, and roamed aimlessly looking for something new or different to engage in. Some parents were so unwell that their ability to closely monitor their children was limited. Programs within detention centres did not always meet the social, emotional and developmental needs of children, particularly the early childhood age range. Young children presented to clinic staff on a daily basis looking for someone to interact with or be given some activity to do like drawing or colouring. A number of detention centre mental health clinicians attributed this issue to a lack of parental control and/or child behaviour difficulties, seemingly without considering the overall impression of the multifaceted impact of the refugee journey and detention on children and families.

Children and young people were kept within the boundaries of the detention centre unless a pre-arranged excursion or appointment had been made. Children must register their names for an excursion. On Christmas Island, excursions were generally limited to the swimming pool or island tours where children were not permitted to get off the bus. Some excursions in Darwin involved visiting natural parkland with man-made water features. Children and families were not always guaranteed a place on the excursion and sometimes had to wait weeks or months before their next opportunity. Security needs often took priority over the psychosocial needs of children and young people. For example, excursions to natural open spaces like waterholes, beaches and some religious sites with large public parklands often did not meet security requirements therefore children and young people did not get to visit those particular places.

* **Is there private space for children and families for living and sleeping?**

Immediate family members generally stay together in the same room. I was in contact with large families some of whom were cramped into small bedrooms. I met with children and parents who slept together in the one room. At least one person in every family I met (child, adolescent and/or parent/caregiver) -suffered from sleep deprivation, ruminating thoughts and/or nightmares during the night. This affected the amount of sleep and respite that other family members received. One family of 5 on Christmas Island were transferred from one family camp to another where they were housed in a much smaller room than their original room. The parents began to argue due to stress and friction caused by having to live on top of each other. As a result, the father began to withdraw from spending time with the family. One parent on Christmas Island reported hearing a conversation between two 6 year old children discussing their parent’s sexual encounters.

**Is the immigration detention facility a clean and pleasant environment?**

The centres that house children and young people are generally old and makeshift. Most bedrooms are air-conditioned. On Christmas Island the bathroom facilities are generally shared. A number of families who I met with on Christmas Island reported unpleasant odours in the bathrooms. Over time several of these individuals decided to restrict their water intake to prevent having to pass urine in the smelly bathrooms.

There is a relatively new public recreation facility on Christmas Island that is adjacent to the detention centres where families and unaccompanied minors reside. The cleanliness and quality of the public recreation facility far exceeds the standard, sturdiness and cleanliness of the detention centres next door. Families and unaccompanied minors have restricted access to this recreation facility (i.e. only through pre-arranged and supervised excursions). The standard and safety of the family camps on Christmas Island are such that families had to be relocated to a compound in the adult men’s facility during a category 2 cyclone this year.

* **In your view, what is the impact of detention on children? Describe your response to the conditions of detention for children.**

A supportive family unit is incredibly vital for the development of children and young people. In detention, family conflict and/or breakdown were common. The limited and restrictive conditions of detention undermine the ability of parents to adequately care, nurture and parent their children. Parents cannot cook their children the nutritious and culturally familiar food they would usually choose. A number of young people I met refused to eat the meals provided in detention and instead lived off a high sugar diet from the canteen. The environment of detention meant that it was very difficult for parents to restrict their child’s exposure to violence, chaos and threat. There was a lot of unconcealed fear and distress in the Christmas Island family camps associated with witnessing other distraught families taken off to Nauru. One child I met began having nightmares of landing on a small island with wild blood-hungry dogs waiting for him. The child would beg the parents not to take him to Nauru (the child would use the word “Nauru” with his parents and was too young to understand his parents had little control over the decisions made in detention). Other parents reported that their children had picked up some of the language commonly used within the detention system, such as “transfer to Nauru”, “self-harm”, “hunger strike”.

The stress associated with detention also weakened parent’s own psychological functioning over time. This has an impact on their ability to provide appropriate emotional and physical support for their children. For example, one Tamil father was re-traumatised by his detention experiences by a persistent feeling of uncertainty and threat to his children’s safety, witnessing violence, experiencing the asylum seeking process as a deterrent to Tamil people, witnessing forced returns of fellow Tamils to Sri Lanka, and an overall disruption to his sense of basic human rights. The psychological effects of his detention experiences on this father included anxiety, helplessness, loss of control, disruption to healthy family attachments with his wife and children, grief, shame and degradation of his identity as a father, destruction of assumptions about humanity and justice, pervasive mistrust, and a shattering of spiritual and existential values; all which once protected him against personal and psychological breakdown. As a result, his children also began to experience life in detention as unpredictable, meaningless and unsafe.

Initially children presented with a higher level of resilience than adults. Clinically significant symptoms of anxiety, depression, and post-traumatic stress in children and young people became more evident over time. The regression appeared to be correlated with the length of time in detention. Various factors appeared to contribute to this including the unpredictability of the detention environment, poor living conditions, lack of child-appropriate resources, parent distress and lack of relationship-based recovery for children after distressing events, deteriorating family relationships, lack of meaningful child friendships, witnessing violence, exposure to illicit behaviour, and difficulty minimising contact with a range of strangers who would come and go without notice (staff and other detainees).

**The impact of the length of detention on children**

* **Does the timeframe of the detention have a particular impact on children? For example, is there any difference in the ways in which a child responds to immigration detention after 1 week, 1 month, 3 months, 6 months, 1 year? Please give examples.**

I found that children and young people were able to manage with the first 2 months in detention. Beyond this point vulnerabilities such as sleep and appetite disturbance, nightmares and night terrors, separation anxiety, social withdrawal, and nocturnal enuresis tended to emerge. A 7 year old child in Darwin APOD gradually began to withdraw over the first 3 months in detention and was showing early signs of selective mutism. Around the 2-month period the child started refusing to consume sufficient amounts of food/drink.

I witnessed the severity of psychological symptoms in unaccompanied minors increase with the length of time in detention. One 16 year old unaccompanied adolescent demonstrated an increase in violent panic attacks, insomnia, and dissociation during the initial 3-month period in detention. This appeared to be associated with a strong sense of injustice and abandonment and a lack of control in avoiding distress triggers inside detention. This young person responded well to positive relationships formed with various staff within the centre however it was evident that institutionalisation and dependent tendencies were manifesting. The young person formed attachments with caring staff members who represented a “parent-figure”. Over time as these staff members would come and go, the young person found prolonged detention more difficult to cope with. These experiences exacerbated the young person’s sense of abandonment, anger and loss.

One 10-year old child began to demonstrate signs of social-emotional regression around the third month in a family camp. The child showed some signs of resilience in the first few months of detention and engaged in activities and reciprocal play with other children. Growing concerns emerged about a role-reversal paradigm between the child and the sole parent (who was psychologically vulnerable). The child took on the role of emotionally supporting the parent and as a result carried an emotional burden disproportionate the child’s age. After a few months the child began to withdraw socially and become increasingly timid and untrusting. This continued to occur despite mental health intervention and the parent recovering to relatively good health and reengaging in the role as parent-caregiver.

**Measures to ensure the safety of children**

* **Can you describe the measures to protect children from harm?**

Services within the detention system include health, welfare, educational and recreational services. There are two different companies involved in health and wellbeing: one healthcare service specialising in medical and mental health and the other company offers welfare, educational and recreational services. In my experience, services generally worked collaboratively alongside each other to an extent. The healthcare service is in place to provide support for individuals identified as having physical and psychological vulnerabilities. Measures to identify psychologically vulnerable individuals in detention are built into the mental health screening and assessment process. For adults these measures include an Induction Health Assessment and a range of universal mental health screens - the General Health Questionnaire (GHQ), Depression, Anxiety and Stress Scale (DASS-21) and a Mental State Examination (MSE). Induction Health Assessments appeared to be conducted in busy environments under time pressure. After induction assessments, periodic health assessments are conducted at 7 days, 1 month, 3 months, and every 6 months or when identified as necessary (i.e. client identified as at risk). A risk assessment is usually conducted when an individual is considered as at risk of self-harm, harm to others, vulnerable to sexual safety or difficulties with daily functioning and to determine whether action is required to reduce the risk. Despite all this, there was not a separately established and formal system for identifying and recording at-risk children and young people using developmentally appropriate screens and assessments. A child version of the MSE was available and clinicians were encouraged to use this when appropriate however this was not built into the recording system. The GHQ and DASS were rarely used with children. Any form of mental health screening for children and young people was usually conducted by mental health nurses. There was no specialist health service for children and young people within detention. I came across one child and adolescent psychiatrist who visited the Darwin family centre once per month for two days. For external / local child health specialists, there were long waitlists of 3-6 months in Darwin. On Christmas Island there were no child health specialists; internally or externally to the detention centre. There was also a lack of specialised support and resources for children with disabilities. Parents of an 8 year old child identified in the family’s home country as having a pervasive developmental disorder were told the child would have to wait 3-6 months to see a local paediatrician to confirm diagnosis and inform treatment. I came across 3 children with special needs at Darwin APOD. The detention conditions for these children were poor, unsafe and lacked the basic needs for their special development. One boy with a pervasive developmental disorder was fixated on running up and down stairs within the family centre. The stairs had hand railings but were not enclosed/fenced. The flight of stairs reached two levels. He did not appear to have good visual skills, spatial awareness, and distance constancy and would fall off the stairs from a height. Children and young people with disabilities had less ability to protect themselves from violence. One wheelchair-bound young person with physical and intellectual disabilities had difficulty moving herself out of the room each time her sister began to cry and self-harm. Two children on Christmas Island were suffering from eye pain and blurry vision. Their mothers asserted this was from phosphate poisoning from the nearby phosphate mine. Both mothers reported no allergies or eye problems in their children’s histories. The mothers reported that the children could not attend school because they were struggling to see. Overall, my impression was there is a shortage of measures in detention to identify and protect children and young people from harm.

* **Is there support for children who may be suffering from trauma either as a result of previous life experiences or in relation to the experience of detention?**

Yes there is support for children and young people who may be suffering from trauma. Anyone who is identified as having a torture or trauma history is generally offered a referral to the specialist trauma support service. There was a consensus within the healthcare service that any individual identified as having been exposed to any form or any extent of torture or trauma would be offered a referral to the trauma support service; where a more comprehensive assessment then takes place. With a high turnover/movement of healthcare staff, sometimes new staff members were not always aware of referral process for the trauma support services. In addition, the referral system appeared to work well for individuals, families who actually disclosed torture and trauma during health assessments. However not all individuals were willing to or had the capacity to disclose traumatic exposure. Some parents held the belief that disclosure of their victimisation and vulnerabilities, and their dependency on services, would be a disadvantage to their family’s asylum application. Some individuals were reluctant to engage with any services associated with the detention system.

At some centres the specialist trauma support services operated on-site within the detention centre whereas at other sites the trauma support service operated in the local community. In the latter case, individuals would be taken to the local clinic via escort and bus. Logistical and security issues sometimes prevented individuals from accessing the trauma support service meaning their appointments would be delayed or postponed.

Retraumatisation from detention experiences appeared just as likely to have a damaging impact on a child’s functioning as past trauma. This was true whether a child or young person was directly affected by their own detention distress or vicariously traumatised through their parent’s detention experiences. A more supportive approach for children and young people who suffer from trauma would begin with the children and their families residing in a safe and stable environment within the Australian community where trauma triggers are minimised. This would also be a more ethical approach to healing childhood trauma.

**Provision of education, recreation, maternal and infant health services**

* **Is formal education available to children? Please describe the types of education that are available. Is it appropriate for the age, the educational level and needs of the child?**

Access to education and school is provided to an extent in the detention system. Children however usually have to wait months before attending school. This can also depend on the availability of vaccinations. Several primary aged children at Darwin APOD waited 3 months to attend primary school after they had their vaccinations. Primary-aged children on Christmas Island are placed on a rotational system where they go to school for 2 week periods and then have to wait weeks and even months before attending again. Adolescents on Christmas Island receive some education sessions within the compounds with visiting teachers from the school. These lessons were held in a shipping container. This was interrupted for some time due to logistical issues. The extent and quality of educational services seemed to depend on the site or location of the centre. Some of the more remote centres have less access to adequate educational and schooling opportunities. My overall impression was that children and young people are detained with no freedom of movement to access appropriate education, some children and young people are denied access to school, and all children and young people are denied their right to a normal, healthy and safe development during their time in immigration detention centres.

* **Can you describe the medical services and support that is available for expectant mothers and new mothers? Can you describe the medical support for babies and infants? Do you think these services are appropriate?**

On Christmas Island there were little or no maternal health services for new or expectant mothers. A maternal health nurse would visit the island for short periods. Expectant mothers were flown off the island for prenatal medical checks and delivery. New mothers are generally returned to Christmas Island no more than 4 weeks post-delivery.In Darwin, one expectant mother had to repeatedly ask the “Property” service (where one can purchase new items with points) for new underwear. Her bladder became weaker during her pregnancy and she needed more than the one pair she originally was given. According to this mother she was told that she cannot have more than two pairs at one time (I cannot comment whether this was an actual Serco rule / policy; it was common for rules to change depending on the officer). When she continued to request that she have another pair of underwear, she was told by the officer to bring her dirty pairs back before she can receive a new pair. She hesitantly did this however the experience was most embarrassing and confusing for her.

**The separation of families across detention facilities in Australia**

* **Are you aware of instances of family separation as a result of immigration detention?**

On Christmas Island there is a procedure by which as soon as a young man turned 18 years, (despite residing in a family camp with his parents and/or siblings) he would be separated from his family and transferred to the adult men’s facility. One 18 year old boy was separated from his mother and taken to the adult men’s facility. Sometime after the separation there was a protest at the adult men’s facility. In response the centre management collectively punished the whole camp by restricting access to the main facilities. This meant that the people in only one compound were allowed outside at any time to use the main facility for up to 2 hours per day (main facilities are where the classes, sports, internet, oval, access to healthcare centre are located). When each compound was opened many people would rush to the internet room. The effect of this was that often individuals would miss their opportunity to use the internet in the daily 2-hour slot. This meant that the son could not easily contact his mother. There was no access to telephone contact between camps. His mother’s health deteriorated after the separation. The mother and son were separated for an ongoing duration, which had been 3 months at the time of my last contact with them. There were no immediate plans by detention operations to reunite them.

* **What forms of contact are available for families to maintain communication?**

There are telephones and telephone cards that people in detention can use to call Australia and oversea. In order to purchase items like USBs and telephone cards, individuals in detention have to earn points. They are generally granted 25 points per week and could earn more points through participating in centre activities. A $10 calling card would generally be worth 10 points. Generally, 1 point is awarded every hour of attendance in a class or activity. There are limited opportunities for communication between detention centres across Australia. Individuals do not have access to a phone to receive calls from family members at other detention centres or camps. Family members separated across detention centres and camps have access to the internet to contact each other. Individuals in detention on Christmas Island have access to 30minutes per day of internet use. There is an internet room that works off a rotational time-limited basis. One sibling unit on Christmas Island had not seen or spoken to each other for 5 months despite arriving together. They were separated and resided in different camps. No formal system existed within detention that offered them an opportunity to visit each other.

**Unaccompanied Minors**

* **What care and welfare services are available for children who arrive in Australia without parents or family members?**

There is one company contracted to run recreation and welfare support for unaccompanied minors within the detention system. I am not overly familiar with the specific model of practice they work with however at least 2 male unaccompanied adolescents whom I was in contact with reported that they formed positive bonds with some of these workers. On Christmas Island the unaccompanied boys reside in a separate compound. The unaccompanied girls reside in the family camp. I had doubt as to whether the unaccompanied girls had as much access to the welfare service as the unaccompanied boys. The unaccompanied adolescents I was in contact with presented with persistent negative emotional states (such as fear, horror, anger, guilt, shame), diminished interest activities, feelings of detachment or estrangement from family back home, persistent inability to experience positive emotions, hopelessness, sleep deprivation, and pervasive mistrust towards the system they resided in. Despite services offered and utilised, it was clear to me that a young person’s sense of persecution and oppression is compounded in detention. In an attempt to restore a sense of control, several unaccompanied adolescents wrote letters to human rights organisations and refugee advocates on the mainland, and spoke to the Human Rights Commission workers and Australian Senator Sarah Hanson-Young when they visited Christmas Island. Such experiences left them with a renewed sense of hope; albeit temporary as they later reported feelings of isolation and abandonment weeks afterwards. Adolescents are in an impressionable developmental phase and often their sense of ‘rights’ is stronger than younger children. When an unaccompanied adolescent’s sense of rights and justice were violated (often daily with every waking thought), they struggled more than others with the cognitive dissonance that subsequently resulted, which caused them further inner disharmony and tension. It was clear to me that the inflexible regime and indefinite circumstances of detention weakened their sense of hope, shattered their assumptions about humanity and justice, and disempowered their levels of resiliency. And having worked with refugee young people in the community post-detention, I have seen how such negative effects on a young person’s sense of self and worldview extend far beyond their time in detention.

One 17 year old unaccompanied adolescent grew increasingly suspicious of the detention healthcare service and doubtful of his ability to make safe decisions. He thought that healthcare service wanted to use medication to sedate and thus control him (it was not uncommon for people in detention to think in this way.) He felt he did not have people around him who he could trust or consult for unbiased advice on things like medication. His sleep and mood were beginning to impact on his daily functioning but he resisted taking pharmaceutical medication. He preferred natural remedies. He said that back in his country he would have access to a variety of natural and nutritious foods to aid with sleep and stress; such foods and aids were not available or accessible in detention. There was also lack of organic, alternative, preventative medicine practiced within detention. Later he was placed on sleep medication however he did not appear fully aware of the nature of the medication. He later ceased taking the medication as it did not respond and he felt overly sedated. As a response to his increasing hopelessness and anger, he started to think about harming himself as a strategy for coping with detention. He had witnessed other young people’s acts of self-harm in detention. He thought that cutting himself could be one way of releasing the pain he felt inside and giving him some control. This only reinforced his sense that the detention environment is unstable and unsafe. From this experience and others, it was clear to me that the needs of unaccompanied minors cannot be appropriately provided for within a detention environment. Unaccompanied minors have particular vulnerabilities and presented more often than others with feelings of isolation, detachment and a loss of confidence. I have seen how prolonged detention of more than a few months can lead to symptomatology such as suicidal ideation, disassociation, and depression in unaccompanied minors. They would be much better supported in a community environment where all psychosocial supports can be accessed in a setting conducive to natural development.

**Assessments conducted prior to transferring children to be detained in ‘RPC’**

* **Can you describe the pre-transfer assessments conducted prior to transferring children to regional processing countries?**

All individuals undergo a health transfer assessment before leaving a detention centre for transfer to another centre within Australia or a regional processing country. A health transfer assessment includes a review of clinical history and a physical examination. There was uncertainty and unpredictability about when exactly an individual may be transferred. I was not made aware how long health transfer assessments were valid for however I noticed that most were conducted in advance with a large window of time; anywhere from a few days to one month prior to transfer to other centres. The general process of pre-transfer assessments involved a healthcare clinician (usually a medical nurse) reviewing an individual’s file and conducting a physical health check-up. The nurse reports any outstanding clinical information regarding the individual’s medical and mental health, and indicates whether the individual is fit to fly (whether they are healthy enough to board a flight). If the individual is being transferred to RPC, the clinician might report on the potential risks of the individual residing at a RPC based on their clinical history.

There appeared to be a lack of developmentally-appropriate pre-transfer mental health assessment for children. There was no specialised assessment protocol that responds to children and young people who are high risk to prevent them in being transferred a RPC. Children and young people do not undergo a specialised child / adolescent mental health assessment by a mental health clinician specifically regarding transfer. A child’s clinical file is reviewed and a physical check-up is completed by a nurse. Sometimes mental health clinicians were asked to be involved in the pre-transfer health assessment process. For example if there was a psychologically vulnerable client, a mental health clinician might be asked to assess or report on the client’s risk status for transfer to a RPC. This practise however was not part of standard procedure across centres. Furthermore, most mental health clinicians were not child and adolescent specialists or highly trained to work with children.

For some time there was health transfer criteria being used by the healthcare service where individuals could be assessed as either being in a high-, medium-, or low-health risk category. Individuals assessed in the high risk category would have been identified as having complex medical and/or mental health requirements that would not be able to be managed at a RPC. Generally speaking, these individuals would not be recommended as fit for travel to a RPC. This meant that highly vulnerable children and young people identified as high or medium risk had more chance of being protected from being transferred to a RPC. However it placed healthcare clinicians in a difficult position having to assess a child’s health risk knowing that a RPC would likely place most, if not all, children and young people at high risk regardless of their current risk status. A number of healthcare clinicians were uncomfortable completing these assessments and there was a sense of pressure from the healthcare service and immigration department to complete assessments quickly and indicate a client is ‘fit to fly’ based on clinical history. This process sometimes made it feel like the healthcare service was there to protect and serve the needs of the immigration department. I noticed this health transfer criteria was not in operation during late 2013 and 2014, since the no-exception policy began. This meant that high risks clients were being taken to RPCs. One woman who was 26 weeks pregnant was transferred to Nauru regardless of clinical information indicating that transfer would subject her to adverse mental and physical health consequences. Clinical information indicated it would be harmful to place this traumatised pregnant woman in a RPC setting where safety, stability, and maternal health services are questionable. Despite clinical reports indicating that the expectant mother would not cope at a RPC and her health and the health of her unborn child would be likely to deteriorate, I was told on numerous occasions by immigration case managers that the new policy means that all people in detention on Christmas Island including children, unaccompanied minors, and pregnant mothers will be subjected to transfer to RPC despite their health status.

Individuals were not aware of the nature of health transfer assessments or the purpose and circumstances of the assessment. Healthcare clinicians were discouraged from disclosing the reasons for the assessment; that is regarding a pending transfer or discharge. This made many clinicians uncomfortable as the approach breaches professional obligations of providing a client with informed consent and it also puts in doubt the validity of assessment results. Rarely did I know of individuals (including children and young people) being formally assessed prior to transfer after they were informed about their transfer and destination. Many individuals residing in detention are often informed about their transfers on the evening before or on the day of transfer. Rarely are individuals given more than a few days’ notice. On Christmas Island, various families were informed about their transfer to Nauru in the very early hours of the morning and given only minutes to pack their bags. Experiences like these were very alarming and disruptive for individuals especially children. It also meant that there was no or very little opportunity for mental health clinicians to work on ‘closure’ in therapy with their clients The closure process is a vital aspect of the therapeutic relationship, particularly for children and young people. This is an example of how security and logistics takes priority over the health and wellbeing of individuals living in detention, and over the priorities of the healthcare service.

**Progress that has been made during the 10 years**

During the previous 10 years there appears to be some improvements in the collaboration between services within detention. There is also a wider variety of professionals working for the healthcare service. Mental health policies are more comprehensive and inclusive. Supervision for mental health workers has also improved.

For many years I have worked with asylum seekers in detention. I have witnessed what children and young people in detention are exposed to and the psychological deterioration they face. Prolonged detention and exposure to violence, family breakdown and uncertainty often emerge as major con­tributing factors for young people’s psychological regression and decline in daily functioning. While children and young people may arrive with pre-existing levels of traumatic exposure and loss, it appears that the experience of prolonged detention itself is most significantly traumatising. The detention regime appears to trigger and revive traumatic memories and exacerbate feelings of power­lessness and abandonment in children and young people. Overall, children and young people in detention are at risk of cognitive and behavioural difficulties, problems in relationships with parents and peers, pervasive mistrust, physical health problems, and a range of psychological symptoms including depression, anxiety, and post-traumatic stress. Public knowledge of this has increased over the last 10 years however children and young people are still in detention.