Mental health consequences of detaining children who seek asylum in Australia and the implications for health professionals: A mixed methods study (2002–2019)

by

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Declaration

I certify that this thesis:

1. Does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and

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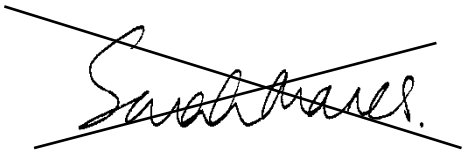

Sarah Mares, 12 September 2019

Abstract

It is no longer contested that indefinite mandatory detention, as implemented by Australia for people who arrive by boat and seek asylum, has harmful consequences. There are extremely high rates of mental illness identified in children and adults held in immigration detention, and the practice involves multiple breaches of human rights.

I first visited detained families held in a remote Australian immigration facility in January 2002. With colleagues I documented and published what I had witnessed. This was the first paper in the professional literature to specifically identify and document the mental health consequences of Australia's immigration policies for children and families. Subsequent papers have provided further evidence of the harms caused by immigration detention of asylum seekers and identified the implications for health professionals.

In the detention environment children cannot be protected from deprivation and repeated exposure to trauma. This includes acts of self-harm and interpersonal violence. Dehumanising experiences are routine, and parenting is undermined. There is a forced communality of people from diverse backgrounds with high rates of comorbid mental illness, particularly post-traumatic stress disorder (PTSD) and depression. Effective health care is compromised by the pathological environment and a lack of independence and transparency in health service provision. Prolonged detention, limited resettlement options and continuing vilification of asylum seekers in political discourse have the combined effect of exacerbating and maintaining mental illness in children and adults.

This thesis brings together a longitudinal body of work using mixed methodologies undertaken between 2002 and 2019. Ten papers are included, primarily based on 24 visits to children in 10 Australian immigration detention facilities. There were many ethical challenges to undertaking research in conventional ways in this restricted, politicised setting: I was granted access to detention facilities primarily as a clinician, not a researcher; data collection required creativity and persistence; and the identity of individual children and adults has been protected. There are consequent and acknowledged limitations in the data which are evidence in themselves of the restrictive and politicised nature of the research environment.

The thesis provides a brief historical context for Australia's reception of asylum seekers, followed by an overview of factors influencing refugee children's wellbeing. The included papers are considered alongside findings from a scoping review of the relevant international literature. Drawings by detained children are incorporated and include their voices and experience as directly as possible. The implications of the work for clinicians and researchers and the role of advocacy and the experience of 'witnessing' are discussed. Reflections on the work have led to new insights, including a framework for understanding the impact of immigration detention on children's mental health, and recognition that this approach to research could be adopted in other unstable, restricted or politicised settings.

The aim of the work has been to make an original and significant contribution to current knowledge about the mental health consequences of detaining children who seek asylum, and the implications of these for health professionals. It has relevance at a time when, globally, there are unprecedented numbers of displaced people and wealthy reception countries are adopting harmful deterrent policies, similar to those practised by Australia.

Acknowledgements

My first thoughts are for the many children and adults who have sought asylum here and, instead of finding safety, have been detained often for months and years. Many of you have shared your stories and your hopes and fears with me. Thank you for your trust and the responsibilities that entails. I hope you have found or are finding safety and are beginning to feel at home, wherever you are. For many of you, I know that you continue to suffer long periods of uncertainty and harm as a direct consequence of our government's policies. The treatment of people who arrive by boat and seek refuge here is an ongoing source of shame, anger and distress for me and many other Australians.

The work that informs this thesis has been necessarily collaborative. It has often been hard and could not have been done alone. My particular gratitude goes to my colleagues, co-authors and friends Louise Newman, Jon Jureidini, Michael Dudley, Karen Zwi, Ros Powrie and Fran Gale. Professors Derrick Silove and Zachary Steel, and Dr Alvin Tay at UNSW, were very generous in sharing their academic knowledge and expertise and supporting my sometime naïve attempts at scholarship. Thank you to Trish and John Highfield and Ngareta Rossell for your support and comradeship over the years, and to other members of the multidisciplinary Asylum Seeker Advocacy Group, which has met regularly since 2002 at the RANZCP building in Rozelle in Sydney.

In preparing the thesis, thank you to Leila Mohammadi, Flinders University Research Librarian, for assistance with the scoping search. I acknowledge the scholarship of my yoga friend Liz Lennon; I learnt a lot from you in our conversations about your doctorate on witnessing. My friend and colleague Michael Bowden gave up his time to do a detailed reading of a penultimate draft, and my husband, Ian, and my mother, Peggy, helped to organise my thoughts and ideas about the discussion section. Thank you also to Ingrid Conde for help with initial formatting of multiple chapters into one coherent document. My friend Michael Wall provided his significant editorial expertise in the final weeks, getting the document into shape and ready for submission.

Many thanks of course to my supervisors, Professor Malcolm Battersby, Associate Professor Anna Ziersch and Dr Rene Pols at Flinders University. This has been an unusual project and I

could not have completed it without your input and support. In very different and complementary ways, you have provided an incisive focus on the task at hand, with attention to structure, methodology and the academic process. You have helped me to create a unified body of work out of 17 years of activity and enabled me to see more in the work than I would have seen myself.

The visits to children and families in immigration detention facilities, the writing, the study and the advocacy have been a part of my life, and that of my family, since 2002. I thank Ian and our now adult children, Ella and Jack Colley, for their love, support and patience over these many years. I know it has taken me away from you at times. To my family and my friends, thank you, thank you. Together we are truly fortunate. Every person, whoever and whatever they are required to do on their journey to safety, deserves the love and sense of belonging that family and community provide for me.

Glossary

Abbreviations used in the thesis

AFP	Australian Federal Police
AHRC	Australian Human Rights Commission (formerly HREOC)
AMA	Australian Medical Association
APA	American Psychiatric Association
APOD	Alternative place of detention
CRC	Convention on the Rights of the Child
DIBP	Department of Immigration and Border Protection
DSM	Diagnostic and Statistical Manual of Mental Disorders (APA)
HREOC	Human Rights and Equal Opportunity Commission (now AHRC)
IDC	Immigration detention centre
IHMS	International Health and Medical Services
MDD	Major depressive disorder
MSF	Médecins Sans Frontières
PNG	Papua New Guinea
PTSD	Post-traumatic stress disorder
RACP	Royal Australian College of Physicians
RANZCP	Royal Australian & New Zealand College of Psychiatrists
RCA	Refugee Council of Australia
RPC	Regional processing centre (on Manus Island and Nauru)
RSA	Regional settlement arrangement
TPV	Temporary protection visa
UMA	Unauthorised maritime arrivals

UAM/UARM Unaccompanied (refugee) minors

UN United Nations

UNHCR United Nations High Commissioner for Refugees

Definitions

Asylum-seeker: Individual who has sought international protection and whose claims for refugee status have not yet been determined.

Boat turnbacks: The Australian Government established Operation Sovereign Borders in 2013. This authorised 'turnbacks', defined as 'the safe removal of vessels from Australian waters, with passengers and crew returned to their countries of departure'. The terms 'turnbacks', 'take-backs', 'turnarounds' or 'pushbacks' are often used interchangeably (Spinks, 2018).

Bridging visas: There are a number of categories of bridging visa, which allow people to stay in Australia while their immigration status is resolved. People on bridging visas are not automatically granted work rights or access to health or other social supports.

Department of Immigration and Border Protection: Over the period 2002 to 2019, the Australian Government department responsible for immigration has been variously called the Department of Immigration and Citizenship (DIAC), the Department of Immigration and Multicultural Affairs (DIMA) and the Department of Immigration and Border Protection (DIBP). Since December 2017 this department has been renamed the Department of Home Affairs.

Detainee: Many people are held in Australian immigration detention facilities who are not asylum seekers or refugees. This term is used to refer to anyone who is detained. This may be anyone without a valid Australian visa, not just refugees and asylum seekers, and includes people awaiting deportation for any reason.

Immigration detention: The practice of holding in closed and restrictive custody adults, children and families who are subject to immigration control. This may occur after they

arrive and seek asylum and while their claim for asylum is considered, or prior to deportation or removal from Australia.

Immigration detention centre: In Australia this includes four different kinds of detention facility: alternative places of detention (APODs), immigration transit accommodation (ITA), immigration residential housing (IRH) and immigration detention centres (IDCs). Since 2007, children and families have usually been held in facilities designated as APODs, ITA or IRH. These feature a number of superficial modifications to the high-security facilities where most adult men are held, but they remain closed and penal environments.

Internally displaced persons: People or groups of individuals who have been forced to leave their homes or places of habitual residence, in particular as a result of, or in order to avoid, the effects of armed conflict, situations of generalised violence, violations of human rights or natural or human-made disasters, and who have not crossed an international border.

Onshore asylum seekers: People who arrived in Australia by air, often with a temporary visa, and then sought asylum.

Overstayers: People who have remained in Australia after their entry visa has expired

People smugglers: Individuals or groups who assist others to illegally enter a country. In the case of Australia, this can include air or sea access to Australia.

Persons of concern: This includes those identified by the UNHCR as refugees, asylum-seekers, internally displaced persons (IDPs) protected/assisted by UNHCR, stateless persons, returned refugees, returned IDPs and others of concern. For more explanation of these categories see UNHCR (2017). Global Trends: Forced Displacement in 2016, p56.

Protection visa: These offer permanent protection to people who are considered to have arrived in Australia legally before seeking asylum. Since 2013 they have not been available to anyone who arrives by boat (unauthorised maritime arrivals) and seeks asylum.

Refugees: Individuals recognised under the 1951 Convention relating to the Status of Refugees, its 1967 Protocol and/or the 1969 Organisation of African Unity Convention Governing the Specific Aspects of Refugee Problems in Africa; those recognised in

accordance with the UNHCR Statute; individuals granted complementary forms of protection; or those enjoying 'temporary protection'. The refugee population includes people in a refugee-like situation.

Resettlement (UNHCR program): The transfer of refugees from an initial country of asylum to another state that has agreed to admit them and ultimately grant them permanent settlement.

Temporary protection visa (TPV): There are currently two kinds of TPV offered by Australia, abbreviated as TPV and SHEV (safe haven enterprise visa). They are offered to people who have been recognised as refugees, allowing them to stay in Australia, to work or study and to access some medical and educational services. They do not offer a pathway to permanent protection. The TPV is a three-year visa. The SHEV allows people who are identified as refugees to stay in Australia for up to five years, and to work or study, providing they live in regional Australia.

Unaccompanied minor (UAM): Child under 18 years old who arrives without a parent or adult guardian and seeks asylum. This abbreviation also includes children under 18 years old who arrive without a parent or adult guardian and who have been found to be refugees, sometimes identified as an unaccompanied refugee minor (UARM).

Unauthorised maritime arrival (UMA): Can be summarised as a person who enters Australia by sea and becomes an unlawful non-citizen because of that entry (federal *Migration Act 1958*, Section 5AA, www5.austlii.edu.au/au/legis/cth/consol_act/ma1958118/s5aa.html).

Unlawful non-citizen: A non-citizen in the migration zone who is not a lawful non-citizen. In practice, people who are not Australian citizens and have arrived in Australia without a valid visa, or whose visa has expired (federal *Migration Act 1958*, Section 14, www5.austlii.edu.au/au/legis/cth/consol_act/ma1958118/s5aa.html)

Note re visas: Information on visa categories relevant to people who are seeking asylum or are refugees was obtained from the Home Affairs Department website (https://immi.homeaffairs.gov.au/visas/getting-a-visa/visa-listing).

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Chapter 1: Introduction

This thesis aims to present an original and significant contribution to the evidence, knowledge and analysis of the implications of Australia's policy of mandatory indefinite detention of children and families who arrive by boat and seek asylum. The body of work on which the thesis is based uses mixed methodologies and includes 10 publications to which I have made a sole or significant contribution. These are research and review papers, book chapters, commentary and editorials published between 2002 and 2018. A chronological list is provided in Table 1.1 at the end of this chapter. A full list of my publications relating to asylum seekers and refugees can be found in Appendix A.

Data was collected between 2002 and 2019 in relation to children and families who were detained by the Australian Government after arriving by boat and seeking asylum. Between 2002 and 2014 I made 25 visits to children and families in 10 separate immigration detention facilities. These visits were undertaken in various capacities as a child and family psychiatrist, as detailed in Appendix B. In addition, between 2002 and 2019 I saw three previously detained children in the community for assessment and therapy and prepared 28 medicolegal reports for detained or previously detained children and families, including children and families held on Nauru. Changes in immigration and border protection policy between 2002 and mid-2019 are included in the contextual framework and inform the discussion and conclusions. The identity of individual children and adults has been protected at all times.

Australia has had a policy of mandatory indefinite detention of all 'irregular maritime arrivals', people who arrive by boat and seek asylum, since 1992. It results in significant suffering for the vulnerable children and adults held within the detention system. Immigration detention and related border protection policies have been explained in terms of deterrence since their inception in 1992, although the then Immigration Minister, Gerry Hand, went on to state that Australia would honour its statutory and international obligations as it always has done, and confirmed that people found to be refugees would be offered protection and resettled (Hand, 1992). This latter commitment is no longer the case. More recently the policy justification has been 'humane deterrence'. This is shorthand for the assertion that deterrent policies, including mandatory immigration detention, are

justifiable because they “combat maritime people smuggling and prevent further deaths at sea” (Dutton, 2018, p. 10).

The research process described here includes systematic investigation and study over time, aimed at establishing facts and reaching new conclusions to add to knowledge about this topic. There is an unavoidable methodological tension in this body of work that requires acknowledgment and examination. This is due to the politicised context of the research and the position of ‘clinician-scientist’ working at the intersection of medical science and the subjectivity of human experience. Psychiatry is a psycho-biomedical discipline that by its nature demands recognition of, attention to and respect for subjective experience. As clinicians we are tasked with using our professional expertise to assist people who are suffering and unwell. Researching the mental health of people detained by the Australian Government has inevitable political implications. The work includes translation of individual and collective ‘lived experience’ of detention into evidence about the impact of government policies. The combined effect of contact with deep suffering, a search for evidence and objectivity, and an attempt to communicate the findings in a polarised and politicised environment has left me feeling like I am shouting into a strong, blustery wind, and in a foreign tongue.

This is a trans-disciplinary area of study. The thesis embodies a confluence of information and analysis from a range of traditionally separate biomedical and humanistic disciplines – child development, medicine, public health, politics, law, ethics and human rights. I have used a narrative synthesis to integrate the findings arising from these diverse sources and disciplines, discussed them thematically, and drawn conclusions about the practical and professional implications for clinicians and researchers. While a majority of the findings and conclusions are historical and documented in the papers, some are new and have arisen in the course of writing the thesis. This is an undeniably polarised environment where, in some ways, neutrality may be neither possible nor desirable. The work has reported on realities that the Government initially tried to deny, and then made it a crime to report (Dudley, 2016).

1.1 A personal introduction

For 30 years I have worked in clinical, academic and consultative roles as a child and family psychiatrist, with a primary focus on families during the perinatal and early childhood periods. I have an established track record as a clinician, educator and clinical academic. My interest has particularly, but not exclusively, been on families with infants and young children, a community often ignored in studies of mental health and illness, and a developmental stage presenting unique opportunities for 'early in life' intervention and prevention, including in relation to transgenerational trauma and adversity. The work has required recognition and celebration of infants and children as active agents in their own development and relationships, the importance of reciprocity and sensitivity as positive qualities of early relationships, and an understanding of the developmental impacts of childhood adversity. My study and practice have included early parenting interventions with families and infants with high and complex needs, as well as work with culturally and linguistically diverse families and communities, including refugee families and those who seek asylum. I have been involved in adaptation and delivery of mainstream programs for families in remote Aboriginal communities and have had invaluable opportunities for collaboration across disciplines and cultural communities in research and training, multidisciplinary education and workforce development. Alongside this I have over 20 years' experience as a Medical Council Hearings Member in statutory programs relating to the health and conduct of medical practitioners. Recognition of my own good fortune and a commitment to social justice, equity and human rights inform my work.

1.2 The research

In 1992, when Australia first introduced a policy of mandatory detention of all people arriving without documentation to seek asylum, conditions in detention, particularly in remote centres were very difficult, with limited access to legal, medical and other supports and high levels of distress and self-harm (Silove, McIntosh & Becker, 1993). In September 1994 the *Migration Reform Act 1992* came into effect, removing a limit on the length of time someone could be detained. The number of detainees, and the length of their detention, gradually increased, and in 2000 and 2001 there were several well-publicised incidents – including riots, fire-setting, hunger strikes, lip-sewing and acts of self-harm – by

detained asylum seekers, particularly in remote facilities such as Woomera in northern South Australia and Curtin in northern Western Australia. Responses to these protests included the deployment of police in riot gear, using tear gas and water cannons. Children were not able to be protected in any way from either the protests and self-harming or the institutional responses to these protests.

In early 2002, soon after the riots, I travelled to Woomera Immigration Detention Centre (IDC) with two colleagues at the request of a lawyer representing several detained families. There were many obstacles, including the distance, the heat and multiple bureaucratic and administrative challenges. After a day of travelling and many delays, we were eventually screened, searched and admitted into the IDC through security and the high razor wire gates and fences.

Once inside and through the air-conditioned administrative block, the experience was shocking: unbearably hot, dusty and sad. There was little or no shade and just a few straggly trees. The ground was dry and stony. In compounds surrounded by high cyclone fences and razor wire, children in bare feet or rubber thongs kicked stones, pushed wheelie bins or walked in aimless circles. Wet, soiled mattresses lined the fences. Flies buzzed around. Women stood in the heat and dust queuing for food and health care. Families were housed in small, dirty rooms separated by just a curtain from other families or single adult men. The bathroom for detainees was filthy, splattered with blood and faeces, piled with waste. The bathroom for staff was cool, quiet and clean.

We waited in makeshift interview rooms with dusty broken furniture as families were summoned on a loudspeaker, called and introduced only by number, not by name. We sat with them and, with interpreters, heard their stories. Memories of the children linger: a listless infant in a fold-up pram facing the wall, no expectation of contact or engagement; a disruptive toddler, pushing everything onto the floor, tearing paper to shreds, putting dirt, paper, rubbish from the ground into his mouth; a quiet, very good and respectful older girl, attempting to speak for her broken father. The parents were variously hopeless, angry, irritable, detached or overprotective. The guards (now designated ‘officers’) were at times kind, condescending, rude, cut-off or intimidating. The despair, desperation and brutality

were palpable. Afterwards I swam up and down in the local pool, my goggles filling with tears, the grief and shock seeping out.

Following that first visit to detained families in Woomera, colleagues and I wrote a paper for *Australasian Psychiatry*, a local psychiatry journal, about the things we had seen and heard, and about what, in our expert capacity, we understood the implications to be for detained children and families. This was the first paper written specifically about the consequences of Australia's immigration detention of children and families and was an early contribution to the international writing on this topic. We wrote: "Immigration detention profoundly undermines the parental role, rendering the parent impotent, unable to provide adequately for their child(ren)'s physical and emotional needs, in an environment where opportunities for safe play, development and education are inadequate or unavailable. Parental depression and despair leave children without protection in an already terrifying and unpredictable place. Children are at high risk of emotional trauma since parents are unable to provide for them adequately or to shield them from further humiliation and acts of violence in a degrading, hostile and hopeless environment" (Mares, Newman, Dudley & Gale, 2002, p. 96). This developmental and systemic focus on young children and on family processes is maintained throughout the body of work. The paper concluded: "Having been witness to the distress of families and children in immigration detention, having asked for their stories and heard them, we feel an obligation to report what we have seen and understood, in order to highlight the plight of these most vulnerable fellow human beings who seek refuge and protection in our country" (Mares et al., 2002, p. 96).

In the months after January 2002, while employed as a locum child psychiatrist in the South Australian Child and Adolescent Mental Health Service (CAMHS), I made two further visits to Woomera IDC and participated in weekly case teleconferences as part of a team managing services and making regular visits and families held there. I contributed to the design and writing up of a study that collected data from 10 families detained in another remote centre (Steel, Momartin, Bateman, Hafshejani, Silove, Everson ... & Mares, 2004) and, with another colleague, wrote up a case sample of 10 families detained at Woomera who were referred to and assessed by the multidisciplinary CAMHS team (Mares & Jureidini, 2004). These papers identified both the pervasive distress and psychopathology in detained families, as

well as the significant limitations that the environment of immigration detention placed on provision of effective, ethical health care.

The data informing the thesis is 'bookended' by visits to detained children and families at Woomera in 2002 and by visits to Christmas Island with the Australian Human Rights Commission (AHRC) in 2014. The human rights violations and evident psychological harm caused by the Australian Government's policies had become undeniable by 2004, including for the Government itself (Mares & Jureidini, 2012). Both major Australian political parties now use the narrative of 'humane deterrence' to justify the policies and their consequences, with "human rights considerations [having] effectively [been] written out of the script" (Pickering & Weber, 2014, p. 1025).

In 2004 I co-authored a book chapter (Steel, Mares, Newman, Blick & Dudley, 2004) exploring the dilemmas facing clinicians attempting clinical work with detained asylum seekers, and in 2007 co-edited a volume of stories by asylum seeker advocates, writing: "To do nothing in these circumstances amounts to doing harm, or at least allowing harm to occur" (Mares & Newman, 2007, p. 217). In a 2016 review paper I summarised the conclusions of the 2004 and 2014 Australian Human Rights Commission inquiries into immigration detention of children *a*s "consistent with Australian and international research which demonstrates that immigration detention has harmful health, mental health and developmental consequences for children and negative impacts on parenting" (Mares, 2016a, p. 11). I concluded that individual clinicians, and the profession as a whole, "have an obligation to oppose these policies" (Mares, 2016a, p. 13).

I include these brief excerpts to illustrate the interrelated issues that wind their way through the thesis. From the first encounter with detained families in January 2002 through to papers written after a week on Christmas Island in 2014, the distress, illness and dysfunction of detained people could not be reported on or understood without acknowledging the institutional and broader political context in which the children and their parents were detained. The clinical issues seen in context then raise inevitable professional and ethical questions. Based on my observations, my clinical assessments of many adults and children, and my underlying professional clinical and academic knowledge and skills, I have put forward evidence to support the argument that immigration detention causes harm and

that effective treatment and intervention in this setting is not possible. What follows logically is advocacy, and the conclusion that the Australian Government's policies on asylum seekers should be opposed.

In the years since first visiting Woomera in 2002, the political response has fluctuated but has not altered substantially, and the policy settings and public narrative have hardened and become more polarised. The harms caused to people detained offshore for years and denied permanent protection, even when found to be refugees, are no longer denied. Instead the notion of 'humane deterrence' is used repeatedly by both major political parties to justify Australia's increasingly punitive response to 'irregular maritime arrivals' who seek asylum. It is arguable that evidence of the harms caused by these restrictive policies has been appropriated in support of the narrative of deterrence and that human rights violations have been excluded from the narrative (Pickering and Weber, 2014).

My professional expertise incorporates the lifetime impacts of childhood trauma and adversity. I also have mandatory obligations as a health professional in relation to reporting and acting to protect children considered at immediate or developmental risk. Talking with detained children and adults, being a direct witness to circumstances and events that most people only hear about through the filter of politics and media, left me with a need to do something. In response to images of suffering, Sentilles, paraphrasing the words of Berger, has written, "First shock. The other's suffering engulfs you. Then either despair or indignation. If despair you take on some of the other's suffering to no purpose; if indignation, you decide to act" (Sentilles, 2017, p. 41).

There is a weighty academic literature – to be acknowledged, but beyond the scope of this thesis to examine in detail – on witnessing and bearing witness to suffering. It includes consideration of what 'witnessing' is, what responsibilities it entails, and what actions and consequences might follow for the witness as well as the witnessed. I refer to it here because the sense of obligation and responsibility that is documented above in the final lines of the first paper (Mares et al., 2002) is repeated and reappears in most or all my subsequent writing about my contact with detained children and adults. Without wanting to inflate my experience, I have felt an imperative to 'bear witness' in the sense outlined by Peters: "To witness thus has two faces: the passive one of seeing, the active one of saying"

(Peters, 2001, p. 709). 'Saying', in my case, has included documenting with colleagues what I have seen and understood, attempting to document and research the impact of these policies for children and families, and considering the professional implications and writing about them.

Many things contribute to how the facts of a situation are reported, including the person who, to use Peters' language, is doing the 'saying'. The primary intention of the thesis is to present the evidence about the impact and consequences of immigration detention for children and parents. In doing this it is necessary to consider the context within which immigration detention occurs and the responses of psychiatrists and other health professionals exposed to these policies. I will attempt a reflection on my own part in this process.

The thesis will first establish a global and political context for the work, then a conceptual and evidentiary framework for thinking about the impact of childhood adversity, including for refugee children. The evidence I have collected and analysed since 2002 about the impact of immigration detention on children and families is included in the form of 10 published papers. The discussion includes a summary of the findings and the unavoidable professional and ethical implications of the evidence. This includes reflection on the role of health professionals as advocates in this highly politicised and complex environment, and on my own part in this. I believe the work has professional and social relevance. Through this body of work, and the inclusion of children's words and drawings, I acknowledge the many people who have been denigrated and knowingly harmed by Australia's response to people who arrive by boat and seek asylum.

1.3 Thesis overview and structure

To consider the evidence and implications of the data, it is necessary to document the political, historical and evidentiary context within which the data was collected, and the papers were written, before presenting and reconsidering the findings.

The thesis is organised into nine chapters. The first four outline a context for the work. This chapter provides an overview of the research, the thesis and the setting and motivations within which the work can be understood. Chapter 2 sets out the geopolitical context – the

international situation, the numbers of displaced people, resettlement programs organised by the United Nations High Commissioner for Refugees (UNHCR), and Australia's changing political responses, including the evolution of deterrent policies since the Indochinese wars in the 1970s. Chapter 3 begins with a summary of the stages of the refugee journey. 'Ecological' or contextual approaches to understanding child development, including the impact of childhood adversity, sometimes termed 'developmental trauma', are then considered, including their application to the circumstances of refugee and asylum-seeking children. Chapter 4 presents the findings from a scoping literature review of the international literature published between 1992 and May 2019 on the mental health and developmental impacts of immigration detention on children and families. This locates my contribution within the academic literature.

The subsequent three chapters present the papers and the findings. Chapter 5 outlines the obstacles to undertaking research with detained asylum seekers in conventional ways, followed by an overview of the methods used in the research and publications. Chapter 6 presents the first six papers. These report primarily on data collected and analysed during and after my visits to children and families held in immigration detention facilities between 2002 and 2014. The children's evidence in their drawings and words is given particular consideration. Chapter 7 presents the other four papers, which focus on the professional and ethical implications of the findings for clinicians and researchers.

The final chapters include discussion and conclusions drawn from the initial research and new propositions arising in the process of integrating and reviewing the evidence and writing the thesis. Chapter 8 considers the findings alongside the relevant local and international literature. A framework and schematic representation of why immigration detention is harmful for children is then proposed. This is followed by an examination of the practice implications of the work for clinicians and researchers. The role of health professionals in advocacy is then considered, followed by brief reflections on the experience of undertaking this work and of 'being a witness'. The strengths and limitations of the research in light of the international and extant literature are then declared. Chapter 9 provides a brief conclusion, identifying the original contribution I and my colleagues have made in documenting over time from a range of sources (using a mixed methods approach), the inclusion of children's voices and images, and the necessary collaboration and

persistence involved in collecting and documenting the findings in this highly politicised and challenging area of research**.**

Table 1.1: The 10 papers presented in the thesis, by date

Number	Paper
1	Mares, S., Newman, L., Dudley, M. & Gale, F. (2002). Seeking refuge, losing hope: Parents and children in immigration detention. *Australasian Psychiatry*, *10* (2), 91-96.
2	Mares, S. & Jureidini, J. (2004). Psychiatric assessment of children and families in immigration detention – clinical, administrative and ethical issues. *Australian and New Zealand Journal of Public Health, 28*(6), 520-526.
3	Steel, Z., Mares, S., Newman, L., Blick, B. & Dudley, M. (2004). The politics of asylum and immigration detention: Advocacy, ethics and the professional role of the therapist. In J.P. Wilson & B. Drozdek (Eds) *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture survivors* (pp. 659-687). New York: Brunner-Routledge.
4	Mares, S. & Jureidini, J. (2012). Child and adolescent refugees and asylum seekers in Australia. In M. Dudley, D. Silove & F. Gale (Eds.), *Mental health and human rights: Vision, praxis, and courage* (pp. 403-414). Oxford: Oxford University Press.
5	Mares, S. & Zwi, K. (2015). Sadness and fear: The experiences of children and families in remote Australian immigration detention. *Journal of Paediatrics & Child Health, 51*(7), 663-669.
6	Zwi, K. & Mares, S. (2015). Stories from unaccompanied children in immigration detention: A composite account. *Journal of Paediatrics & Child Health, 51*(7), 658-662.
7	Mares, S. (2016a). Fifteen years of detaining children who seek asylum in Australia – evidence and consequences. *Australasian Psychiatry*, *24*(1), 11-14.
8	Mares, S. (2016b). The mental health of children and parents detained on Christmas Island: Secondary analysis of an Australian Human Rights Commission data set. *Health and Human Rights*, *18*(2), 219-232.
9	Zwi, K., Mares, S., Nathanson, D., Tay, A. K. & Silove, D. (2018). The impact of detention on the social–emotional wellbeing of children seeking asylum: A comparison with community-based children. *European Child & Adolescent Psychiatry*, *27*(4), 411-422.
10	Silove, D. & Mares, S. (2018). The mental health of asylum seekers in Australia and the role of psychiatrists. *BJPsych International, 15*(3), 65-68.

Chapter 2: Asylum seekers and refugees – Australia's response

"… the concept of 'asylum' has moved from a positive image of the 'settler refugee' to the refugee 'burden'" (White, 2004, p.4)

This chapter will provide a brief historical and political context for Australia's current immigration and border protection polices as they apply to 'unauthorised maritime arrivals' (UMAs) – people who arrive by boat and seek asylum.

2.1 Introduction

Since 1992, Australia's *Migration Act 1958* has required that all 'unlawful non-citizens' (people who are not Australian citizens and have arrived in Australia without a valid visa) are detained, regardless of their circumstances or whether they pose a risk to the community. Detention is for an indefinite period until they are granted a visa or leave the country. A majority of the adult and child asylum seekers who have arrived in Australia by boat and sought asylum have been detained, often for years (Australian Human Rights Commission [AHRC], 2019). Once their refugee claims are processed, the vast majority are found to be refugees, that is, to have a valid claim for protection under the Refugee Convention (UNHCR, 2010) (Phillips & Spinks, 2013; Refugee Council of Australia [RCA], 2019a).

Historically, most people held in immigration detention have not been unauthorised maritime arrivals (UMAs) but 'overstayers', people who have remained in Australia after their entry visa has expired and/or people whose visa has been cancelled or who are otherwise not authorised to stay. The number of boat arrivals has fluctuated considerably in recent decades (see Figure 2.1). Even in years when UMA numbers were high, almost twice as many people arrived in Australia by air and sought asylum. These people are known as 'onshore asylum seekers', and there is recent concern that this has become an organised route for 'people smugglers' (Rizvi, 2018). Compared to onshore asylum seekers, a much higher proportion of those arriving by boat are subsequently recognised as refugees

(Phillips, 2015). Despite this, political and media debate has predominantly focused on mandatory detention as it applies to asylum seekers who arrive by boat (Rizvi, 2018).

Over the past 27 years the mandatory detention policy has been adjusted in response to domestic political circumstances but overall has been maintained and progressively extended by successive governments to include changes to the migration zone, offshore and third country processing, and 'boat turnbacks'. This involves the Australian naval and coast guard vessels towing boats out of Australian waters and at times returning them to their country of origin.

A summary of the major changes in Australia's immigration and border protection policy since 1992 is provided in Appendix B.

2.2 Global trends and data on 'people of concern'

Twenty-five years ago, in 1992, when Australia first implemented a policy of mandatory indefinite detention of anyone arriving to seek asylum without valid documentation, the UNHCR estimate for total numbers of 'people of concern' was around 23 million (UNHCR, 1994). This number has steadily increased, with rapid rises around the turn of the century and again around 2012, reflecting the consequences of war and continuing ethnic conflict – most notably in the Middle East (including Afghanistan, Iran, Iraq, Syria and northern Africa, (particularly the former Sudan and Somalia), and parts of Asia (notably Sri Lanka, Burma, with the Rohingya crisis, and Thailand). It is not a coincidence that most boat people come from places where there is or has recently been war, conflict or other human insecurity and displacement (Phillips & Spinks, 2013).

The most recent UNHCR report on global trends estimates that in 2018 the world's population of forcibly displaced people had grown to a record 70.8 million (UNHCR, 2019). The total number of displaced people described in this report includes 25.9 million formally recognised as refugees and another 3.5 million asylum seekers – people who are seeking international protection but whose refugee status is yet to be determined (UNHCR, 2018). Over half (52%) of all displaced people described in the report were aged under 18, and in 2017 at least 138,600 registered asylum seekers were unaccompanied children, though this number is considered an underestimate (UNHCR, 2019).

Eighty-five percent of the displaced people were in developing nations, with only a small percentage reaching North America, Europe and Australasia (UNHCR, 2019). Per head of population, Australia receives a small number of asylum seekers. In 2017 Australia received only 0.83% of asylum applications globally, a global ranking of 23rd per capita and 65th when gross domestic product (GDP) is taken into account (RCA, 2017a). Australia has never been listed by the UNHCR as among the nations responding to high numbers of people seeking protection. Australia does contribute to the UNHCR resettlement program (see below), but less than 1% of the world's displaced people are resettled in this way.

Despite a light resettlement burden, Australia, along with other wealthy nations, has implemented increasingly harsh policies which are now explicitly intended to deter and prevent asylum seekers from entering their borders (Pickering & Weber, 2014). Australia has arguably led the way in mandating the indefinite incarceration of all children and adults arriving by boat and in implementing restrictive policies for asylum seekers living in the community. This includes various forms of temporary protection, with limited or no access to work, health services, higher education or family reunion.

2.3 Refugee resettlement

Eighty percent of displaced people are provided asylum in neighbouring countries, with low- and middle-income countries in developing regions carrying a disproportionate responsibility (UNHCR, 2019). The UNHCR manages a program to resettle people whose claim for refugee status has been recognised but who remain at risk in the country where they have sought protection. Globally, less than 1 percent of the world's refugees are resettled under this program. Resettlement states are expected to provide refugees with legal and physical protection, including a path to citizenship and access to civil, political, economic, social and cultural rights similar to those enjoyed by nationals (UNHCR, 2018). Australia is one of only 20 countries that formally participates in the UNHCR resettlement process (Karlsen, 2016), and the reception of resettled refugees by Australia stands in stark contrast to that given to UMAs (Phillips & Spinks, 2013). In 2017 just over 23,000 people were resettled by Australia, which was 0.65% of all people eligible for resettlement (RCA, 2017a). Asylum seekers in Australia are regularly referred to derisively in the media and by politicians as 'queue jumpers', the identified 'queue' presumably referring to those 25.9

million refugees currently identified by the UN and not yet 'submitted' to third countries for resettlement (UNHCR, 2019).

2.4 Migration to Australia 1788–1992

Australia is a unique and evolving democratic multicultural nation, often called a land of immigrants. The second verse of our national anthem includes the lines, "For those who've come across the seas, We've boundless plains to share". These lines can seem ironic in the face of current immigration and border protection policies, and the national anthem does not acknowledge our colonial history. Arrival by the British around 1788, variously called invasion or colonisation, was not followed by a treaty or adequate reconciliation with Australia's first peoples, many of whom remain profoundly disadvantaged on multiple measures of wellbeing (Gannon, 2018). Papastergiadis (2005) suggests that denial of responsibility and guilt about the consequences of European settlement of Australia contribute to national anxiety about another possible invasion, this time by 'non-whites', and helps explain Australia's policies over time in relation to migration and to people arriving unauthorised by boat (Papastergiadis, 2005; Tascon, 2002). In this narrative, asylum seekers are cast as potential threats to national sovereignty and to 'ordinary' (white) Australians.

European settlement was established in the 1780s, and the first assisted migration began around 1830 to provide workers for the new colonies. The goldrush saw many Chinese immigrants arrive and settle around 1860, but racial tensions followed, and the number of Chinese immigrants was restricted in subsequent decades. Since Federation in 1901 there have been successive waves of migration, mostly for pragmatic, nation-building reasons. One of the first acts of the new parliament after Federation was to pass the *Immigration Restriction Act 1901*. The intention was to prevent 'non-whites' from entering Australia as immigrants. These laws created the legal foundation of what became known as the White Australia Policy (Meaney, 1995).

Australia's intake of refugees after World War II was, on a per capita basis, one of the largest of all countries. The reception policy followed versions of the White Australia Policy until the aftermath of the Indochinese wars of the 1970s, when Australia received more

than 100,000 refugees from South-East Asia (Phillips & Spinks, 2013). In 1972 the Government formally abolished the White Australia Policy and adopted a policy of resettlement in which newcomers were offered permanent residency and family reunion (leading to full citizenship) and access to English language lessons, work opportunities, education and health care (Meaney, 1995). Between 1976 and 1982, over 2,000 asylum seekers from Vietnam arrived in Australia directly by boat and the phrase 'boat people' entered the national lexicon as a term for UMA (Phillips & Spinks, 2013). This became known as the 'first wave' of boat people to Australia. These people were supported to settle in Australia, and another 200,000 more refugees whose claims for asylum had been processed in camps in Malaysia, Hong Kong and Thailand were also accepted. The generous and welcoming nature of this resettlement policy is likely to have contributed to the remarkably sound mental health outcomes recorded for the Vietnamese in Australia two decades later (Steel, Silove, Phan & Bauman, 2002).

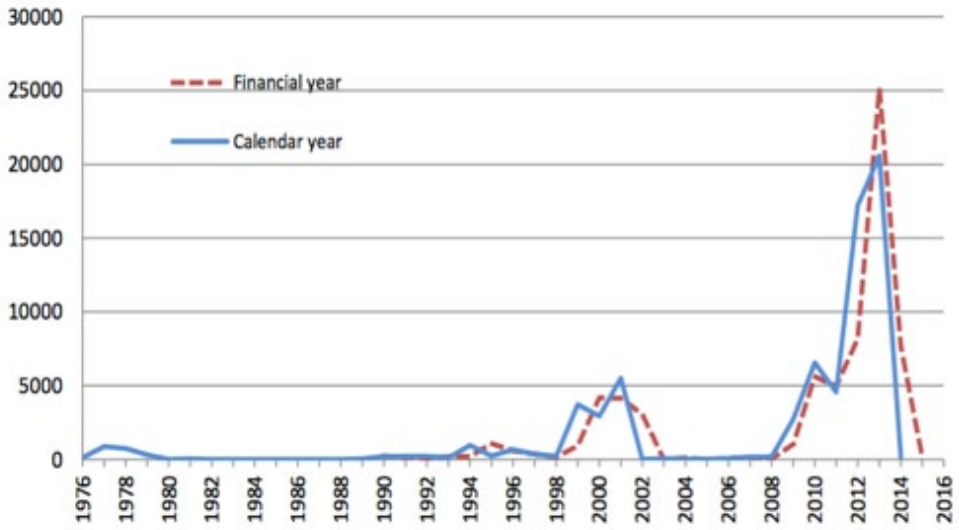
2.5 The evolution of policies of deterrence

The number and origins of people arriving by boat to seek asylum in Australia has fluctuated significantly since the 1970s in line with various global events (see Figure 2.1). In the late 1980s there was a 'second wave' of around 300 'boat people' a year seeking asylum, mainly from Cambodia, Vietnam and southern China. This resulted in a fundamental change in government policy (Phillips & Spinks, 2013).

In 1992 the Government strengthened mandatory indefinite detention policy applying to all adults and children arriving by boat without valid documentation. Around 1999 increasing numbers of people again began arriving by boat to seek asylum, sometimes assisted by 'people smugglers', people who assist others to illegally enter a country. This is known as the 'third wave', predominantly from Middle Eastern countries, and its numbers increased following the war against the Taliban by the United States-led coalition. Around this time, temporary protection visas (TPVs) were introduced, increasing the barrier to permanent protection and settlement. In late 2001 the Norwegian vessel the MV *Tampa* was refused entry to Australian waters after rescuing 438 mainly Afghani refugees from a stranded boat off Christmas Island, a remote island northwest of Australia in the Indian Ocean, marking another turning point in immigration policy (Mares, 2002). It heralded the excision of

Christmas Island and other outlying areas of northern Australia from the migration zone and sparked international condemnation.

Figure 2.1: Boat arrivals by calendar year 1979–2015



Source: Phillips, 2017, p. 4. Reproduced with permission.

As part of what became known as the 'Pacific Solution', the Australian Navy was authorised to turn boats back into Indonesian waters (Kaldor Centre for International Refugee Law, 2017). Those asylum seekers who reached Australia had their asylum claims processed on Christmas Island. Others were sent to newly established offshore processing centres on Manus Island in Papua New Guinea (PNG) or the island nation of Nauru. These offshore detention centres in Nauru and PNG were temporarily closed in 2008.

In 2004 the then Human Rights and Equal Opportunity Commission (HREOC) published a damning report following an inquiry into immigration detention of children (HREOC, 2004). Between 1 July 1999 and 30 June 2003, 3,125 children arrived by air with visas and sought asylum (HREOC, 2004, p. 66). They came mainly from Fiji, Indonesia and Sri Lanka and were not detained. Only 25.4% of them were found to be refugees. In contrast, 2,184 children arrived by boat, without visas, and were detained. Once their asylum claims were processed, 92.8% were recognised as refugees. Almost 50% of the detained children were from Iraq or were Sabean Mandean Iraqi families who had been living in Iran, and 37% were

from Afghanistan mainly of the Hazara minority ethnic group. In addition to the HREOC inquiry, public awareness of the conditions for these refugees – including a detained and starving child (Whitmont, 2001; Zwi, Herzberg, Dossetor & Field, 2003), the wrongful detention of a mentally ill Australian resident and the wrongful deportation of another, (Commonwealth of Australia, 2005; Commonwealth Ombudsman, 2005), hunger strikes and violent protests in some remote detention centres, and deaths at sea (Kevin, 2004) – contributed to a temporary change in public and political sentiment about mandatory indefinite detention. Following a marked fall in boat arrivals between 2003 and 2007, in 2008 the Government announced the closure of the centres on Manus Island and Nauru.

Around 2010 the 'fourth wave' of people arriving by boat to seek asylum in Australia began. In 2012 more than 100 boats arrived, carrying over 5,000 refugees, mostly from Iran, Iraq, Afghanistan and Sri Lanka. The second largest group consisted of stateless people, predominantly minority ethnic Rohingya people from Myanmar (Burma) (AHRC, 2014, p. 51). It is estimated that, between January 2009 and June 2017, 51,781 people arrived by boat to seek asylum; over that same period around 900 people are believed to have drowned at sea as overcrowded boats sank and capsized (RCA, 2017b). In September 2012, third-country processing of asylum applications was reintroduced and a regional settlement arrangement (RSA) was announced. This meant that people arriving by boat after 19 July 2013 were transferred to Nauru or Manus Island in Papua New Guinea (PNG) and denied resettlement in Australia.

In November 2013 boat 'turnbacks' to Indonesian waters, as well as 'take-backs' to their country of origin, were reintroduced as part of Operation Sovereign Borders (Spinks, 2018). There is argument about the safety and legality of these operations and considerable secrecy about how many boats and people seeking asylum have been turned back. It is estimated that this has included at least 33 boats and 810 people since September 2013 (Spinks, 2018). There has been a marked fall in numbers of people arriving to seek asylum from the peak of 25,173 people in the 2012/13 financial year to 157 people in 2014/15 and zero in recent years (Spinks, 2018). This fall in arrivals is used as an argument to support the continuance of harsh deterrent policies and use of boat turnbacks. While the practice of boat turnbacks is criticised on legal and humanitarian grounds, it is likely that this deterrent policy, more than others, has contributed to the fall in asylum applications by people

arriving by boat (Spinks, 2018). At the same time, the number of people arriving by air and seeking asylum in Australia increased threefold between 2014 and 2018. In 2014/15 there were protection applications made by 8,587 people who arrived by air, rising to 27,931 in 2017/18, mainly from China, Malaysia and India. By comparison, the highest number of boat arrivals ever recorded was 18,365 in 2012/13. Arguments about border management and deterrence rarely include information that more people arrive by air than boat to seek asylum and that the percentage found to be refugees is very low (e.g. only 2% of applications found to be meritorious for people from Malaysia) compared with 75–90% for people who arrive by boat (Rizvi, 2018; RCA, 2019a).

For almost 18 months, from July 2013 to December 2014, adults and children remained detained in Australian mainland centres and on Christmas Island while the RSA was negotiated. The number of children and adults in immigration again soared, as did the length of time they were detained.

A second Australian Human Rights Commission inquiry into immigration detention of children was conducted in 2014 (AHRC, 2014). Just prior to public release of the AHRC inquiry report, in December 2014, detention of children and families on Christmas Island ended. All those detained were transferred to Nauru or Manus Island, returned to their country of origin, or held in Australian centres or on temporary visas in the community.

2.6 Human rights inquiries

Australia does not have a Bill of Rights but is a signatory to the International Covenant on Civil and Political Rights (ICCPR) (1966), the Convention Related to the Status of Refugees (Refugee Convention) (1951, as amended by its 1967 protocol), and the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (CAT) (1987). In December 1990 the Convention on the Rights of the Child (CRC) was ratified (UN, 1990). Most of the CRC rights are largely enacted in policies for Australian children but are not incorporated into Australian law.

Australia's immigration and border protection policies and practices have received sustained criticism from local and international human rights organisations (Amnesty International, 2016; UNHCR, 2015) and from professional medical bodies (RANZCP, 2003;

AMA, 2015). The rights of detained asylum seekers – including rights to work, education, human dignity, freedom from discrimination, equality, freedom from torture, privacy, access to information, and freedom of association, assembly and movement – are all demonstrably compromised, with consequent impact on the right to health (Mares, 2016b). There is undeniable evidence of harm caused by indefinite detention and identified breaches of the International Bill of Rights, the ICCPR and the CRC (HREOC, 2004; AHRC, 2014). In recent years there has been particular concern about conditions for those held indefinitely on Nauru and on Manus Island, including within the Australian parliament (Commonwealth of Australia, 2017). In 2015 the UN Special Rapporteur on Torture concluded in regard to the regional processing centres that, "the Government of Australia ... has violated the right of the asylum seekers, including children, to be free from torture or cruel, inhuman or degrading treatment, as provided by articles 1 and 16 of the CAT" (UNHRC, 2015, p. 9).

The AHRC, previously known as the Human Rights and Equal Opportunity Commission (HREOC), has conducted two inquiries into immigration detention of children. The first gathered evidence relating to the period from January 1999 to December 2003. The inquiry report states that the failure "to take all appropriate measures to protect and promote the mental health and development of children in immigration detention … not only constitutes a breach of a child's right to mental health, development and recovery, it also amounts to cruel, inhuman and degrading treatment" (HREOC, 2004, p. 13). The inquiry found Australia in breach of multiple articles of the CRC, in particular Article 3 (1), which states, "the best interests of the child must be a primary consideration in all actions concerning children" (HREOC, 2004, p. 214).

The second inquiry, held and reported on in 2014, gathered data relating to the period from 1 January 2013 to 30 September 2014. It also considered law and policy developments over the 10-year period since the previous inquiry, i.e. 2004 to 2014. The report states: "the laws, policies and practices of Labor and Coalition Governments are in serious breach of the rights guaranteed by the Convention on the Rights of the Child and the International Covenant on Civil and Political Rights" (AHRC, 2014, p. 11). The report concludes: "The overarching finding of the Inquiry is that the prolonged, mandatory detention of asylum seeker children

causes them significant mental and physical illness and developmental delays, in breach of Australia's international obligations" (AHRC, 2014, p. 13).

In the decade between the two inquiries, public and political sentiment about immigration detention, particularly of children, fluctuated as evidence of the harms caused by immigration detention was consolidated. Political responses to the two inquiries differed (Mares, 2016a). In 2004, evidence of the harms caused by immigration detention was then considered new, and, while the Minister for Immigration disputed the findings, there was no sustained attack on the AHRC itself or those who had provided submissions to the inquiry. Following a change of government in 2007, the *Migration Act* was amended to affirm that minors seeking asylum would be detained only as a last resort; at the same time, TPVs were abolished, and the Nauru and Manus Island detention centres were closed.

In marked contrast, the 2014 report was received with great hostility (Gratton, 2015; Mares, 2016a). There was a sustained political attack on the AHRC, including claims that the Government no longer had confidence in the AHRC president and that she should step aside. There was little attempt to deny the evidence that Australia's policies cause significant harm. In addition, in the Government's response to findings and recommendations of the inquiry (included in the inquiry report), the methodology was questioned, including its "Over reliance on the Commission's own experts; the draft report makes extensive reference to and gives disproportionate weight to, the opinions and submissions of the medical consultants that were engaged by the Commission" (AHRC, 2014, p. 308). In the following year, the *Australian Border Force Act 2015* was passed; it had the effect of criminalising medical and other witnesses who spoke out about their experiences within immigration detention *(*Dudley, 2016). This Act was only amended in response to a High Court challenge, leading to changes in October 2016, initially excluding doctors and then, in August 2017, other health workers, teachers, lawyers and social workers from the threat of jail terms under the *Border Force Act* secrecy provisions (Dudley, 2016).

2.7 Recent developments in immigration and border protection policy

In April 2016 the PNG Supreme Court ruled that the Manus Island detention centre was illegal (Tlozek, 2016). The facility was closed on 31 October 2017 but detainees initially refused to leave, fearing for their safety (Fox, 2017; Sundram & Ventevogel, 2017). There had been repeated incidents of violence, abuse and self-harm in offshore detention on Christmas Island, Nauru and Manus Island, including the violent deaths of at least 12 people (Commonwealth of Australia, 2017; Christmas Island Medical Officers, 2013; Moss, 2015). In 2018 UNHCR staff described the situation as a humanitarian crisis, writing, "It is not a figure of speech when we say as UNHCR staff that we have run out of vocabulary to describe the harm wrought by offshore processing and neglect" (Stubberfield, 2018). Children held on Nauru were self-harming or refusing to eat, drink or speak. This is indicative of 'resignation syndrome' and constitutes a medical emergency (Davidson, 2018c; Newman, 2019).

Ninety percent of asylum seekers detained between 2009 and 2013 were found to have valid claims for protection. Despite this, current government policy denies permanent resettlement of any of these refugees in Australia. Arrangements to resettle people from Nauru and Manus Island in third countries has been slow. A small number were accepted by the US, but resettlement offers from New Zealand have been repeatedly refused. There were prolonged delays in processing asylum claims after 2013, and in April 2016 around 28,000 people were still awaiting determination of their asylum claims while being held on Nauru or living on temporary visas in the Australian community (RCA, 2019a). This cohort was designated the 'Legacy Caseload' by the Government (Kaldor Centre, 2019). By 31 January 2018 the claims of almost half of this cohort had been processed, with more than 70% being recognised as refugees. These people face multiple restrictions on their access to support and basic services in the Australian community and most are still awaiting permanent resettlement (RCA, 2019a; Kaldor Centre, 2019).

In the second half of 2018 there was another gradual shift in public sentiment about the continued incarceration and lack of resettlement options for adults and children on Nauru and for adult men in PNG. By December 2018, after more than five years in various forms of detention and limbo, most children and families were finally transferred from Nauru to

Australia and a few to the US (Davidson & Wahlquist, 2018). The majority of transfers to Australia happened only after successful pro bono legal and medicolegal actions in the Federal Court based on the deteriorating health and mental health of these adults and children (Davidson, 2018a, 2018c). Many single men remain on Manus Island or in PNG to this day.

In February 2019 the Australian parliament, against the wishes of the Government, passed what is known colloquially as the 'Medevac legislation' or the 'Urgent Medical Treatment Bill' (RCA, 2019b). This was done in response to the continuing deterioration and crisis in the health of adults held for over five years in limbo on Nauru and Manus Island. Coronial reports and evidence, including from government inquiries, confirmed a lack of transparency and efficiency in meeting the health needs of asylum seekers detained offshore (Commonwealth of Australia, 2017). The Medevac legislation is intended to ensure that people requiring urgent medical care can be transferred to Australia for treatment. The Government opposed the passage of the Bill and continues to obstruct its implementation (Davidson, 2019a, 2019b). As an example, the Home Affairs Department recently sought to block transfer of a critically ill asylum seeker to Australia for treatment though legal action in the Federal Court. His transfer had been recommended by two medical practitioners in Australia. The Federal Court ruled against the department and upheld aspects of the legislation. The Minister for Home Affairs provides no supporting evidence but continues to conflate medical transfer and treatment in Australia of seriously unwell people with threats to border security, and to vilify 'advocate doctors' along with asylum seekers (Lewis, 2019). As exemplified in recent ministerial statements, the issue remains entrenched in party political scaremongering tactics, and how the Bill will be implemented remains divisive and highly politicised (Davidson, 2018b, 2019b; Lewis, 2019).

2.8 Conclusion

This chapter has provided an outline of the historical and political context within which Australia detains all children and adults who seek asylum after arriving by boat. Chapter 3 outlines conceptual and evidentiary approaches to understanding contextual influences on children's development, including exposure to adversity. Together these geopolitical and

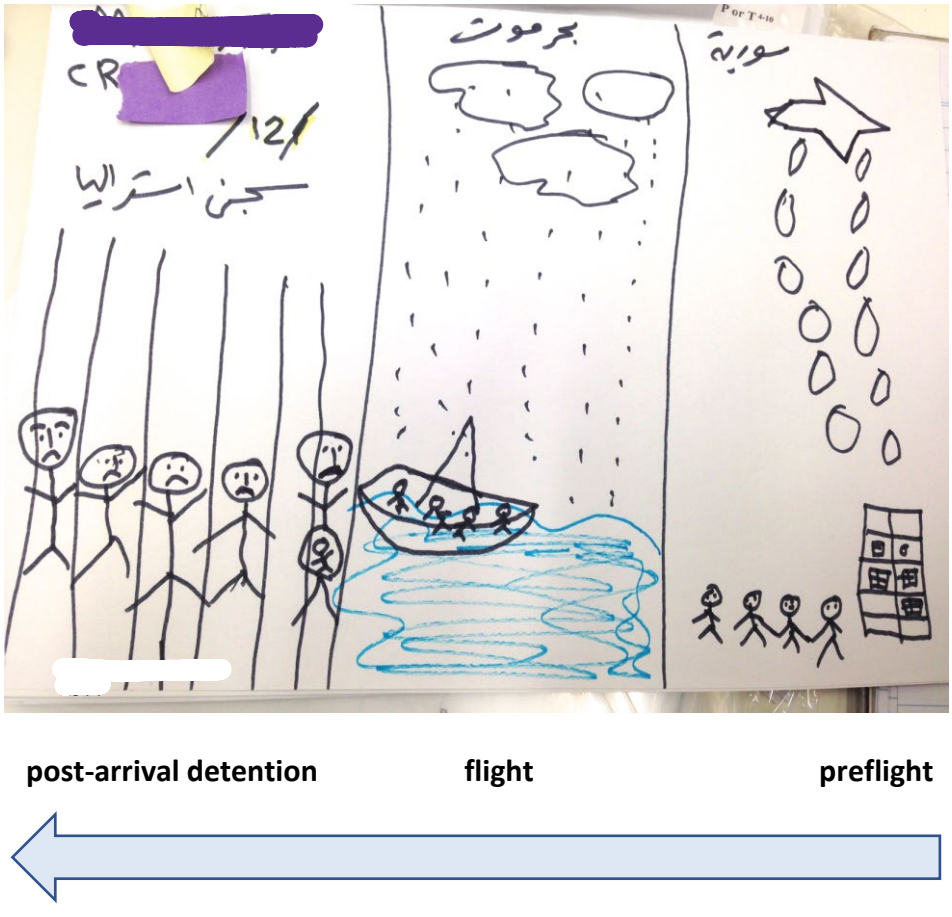
conceptual frameworks provide a context within which evidence about the impact of immigration detention of children who are seeking asylum can be considered.

Chapter 3: Influences on the health and development of refugee children

This chapter introduces the stages of what is known as the 'refugee journey'. An overview of the influence of contextual factors on development follows, including risk and protective factors and exposure to adversity at different developmental stages. The cumulative risks faced by displaced and refugee children, and the particular impact of immigration detention on children and families, can then be understood within ecological and developmental frameworks.

3.1 The refugee journey

Figure 3.1 The refugee journey



This drawing by an 11- or 12-year-old child was presented during the 2014 AHRC inquiry (AHRC, 2014) and was previously included in a paper written after visits to Christmas Island in 2014 (Mares & Zwi, 2015). The drawing clearly illustrates what are often called the stages of the refugee journey. Read from right to left, these are preflight (bombing), flight (the

boat journey) and post-arrival detention. The final stage, settlement and safety, is missing from the drawing and from the experience of detained asylum seekers. The drawing is de-identified but includes a remnant of the child's ID number.

This image illustrates how children in families who seek asylum can be exposed at different ages and in different ways to the adversities associated with forced displacement, and that family composition may change over time. Hypothetically, the older children may have had a settled life with two parents, school attendance, extended family and friends before the war and flight, or they may have been born into social and political conflict and have known very little else. Older children will have understood the reasons for their flight and the dangers the family faced in different ways, depending on their age and the capacities of their parents to support and protect them. The fetus who appears in the detention photograph has not been exposed directly to bombing, the dangers of the boat journey or the deprivations and traumatic exposures associated with living in detention. Nonetheless, in utero they are exposed to maternal stress and anxiety and to other potential adversities associated with detention that can impact on maternal and fetal health. These include limited diet and antenatal care, and maternal mental illness. The many babies born during flight or into detention are exposed to the adversities of the detention environment, including the impacts of poor parental health, mental illness, and limited developmental screening and medical care.

Vulnerability to mental illness

There are various approaches to modelling the impact on vulnerability to Post Traumatic Stress Disorder (PTSD) and other psychiatric disorders of cumulative exposure to stressful war experiences, displacement and what have been called the 'daily stressors' associated with resettlement (Miller & Rasmussen, 2010; Sim, Bowes & Gardner, 2018). These include questions about the relative salience of exposure to various kinds of trauma and stress, and the role of some experiences as potential 'mediating' or 'moderating' factors in relation to initial traumatic exposures (De Schryver, Vindevogel, Rasmussen & Cramer, 2015; Miller & Rasmussen, 2010; Neuner, 2010; Miller & Rasmussen, 2014).

Literature on the significance of pre- and post-migration stressors is relevant when attempting to understand the contribution of prior and current traumatic exposures and

'ecological stressors' for detained children and families. Adverse exposure is highly variable. As Miller and Rasmussen note, "Everyone in a refugee camp has been displaced, and everyone must contend with the numerous challenges and hardships of camp life. However, not all camp residents have necessarily been directly exposed to the violence that caused the displacement" (Miller & Rasmussen, 2010, p. 13). For detained people, the description of post-migration experiences as 'daily stressors' does not adequately encompass the ongoing trauma and prolonged uncertainty they experience. Exposure to violence, self-harm, family separation and the penal detention environment constitute traumas in themselves. This debate highlights the complexity of attributing linear causality or taking a simple accumulative approach when attempting to develop explanatory models of risk and intervention for children who are detained in the process of seeking asylum.

The ADAPT model

The Adaptation and Development After Persecution (ADAPT) model (Silove, 2013) provides a bridge between narratives about the refugee experience and ecological approaches to understanding child development. With a focus on systemic and environmental factors, it provides a stark contrast to understandings of trauma focused primarily on individual psychopathology, such as those captured in the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2013). The ADAPT approach proposes that the five core psychosocial pillars of a stable society are fundamentally disrupted by mass conflict and subsequent displacement. These pillars are: (1) systems that support actual and perceived safety and security; (2) interpersonal bonds and networks; (3) access to justice; (4) social and personal roles and identities; and (5) the capacity to undertake activities that confer existential meaning, such as cultural, religious and spiritual activities, as well as those associated with political and social beliefs and values (Silove, 2013). This model offers a broad and systemic conceptualisation of factors influencing the trauma and disruption experienced by people and communities exposed to mass conflict, including those who seek recognition and resettlement as refugees. A key principle is that "effective repair of the five core psychosocial pillars is essential to enable refugees to overcome trauma-related mental distress; the more successful the recovery program, the less the need for individual interventions such as psychotherapy" (Silove & Mares, 2019, p. 148). Silove has previously written, "repair of the social environment is the best remedy for most

refugees (Silove, 2005, p. 75). The implication of this is that many of the precipitating and perpetuating factors of distress and mental illness in displaced people are systemic, interpersonal and social in nature. The ADAPT framework has clear application to the wellbeing of adults and children held in immigration detention facilities.

The passage of time

A temporal or chronological perspective – past, present and future – is necessary when considering the effects of immigration detention on children and their parents. The 'refugee journey', as described above, occurs over time – the stages of preflight, flight and post-arrival, including within detention. Flight implies hope for an anticipated future that is better than that which has been left behind. Hope includes a future orientation and "Grounds for believing that something good may happen".[1] Asylum seekers hope for refuge and safety. Frankl, writing about concentration camp experiences, described the indefinite nature of their imprisonment as "a provisional existence of unknown limit"; he wrote that "someone who could not see the end of his 'provisional existence' was not able to aim at an ultimate goal in life. He ceased living for the future" (Frankl, 1946/2008, p. 87). Since 2014, Australian rhetoric about restrictive immigration policies, including indefinite detention, offshore processing and refusal of resettlement in Australia, has had the express intention of removing hope in order to deter others from risking the journey by boat to seek asylum in Australia (Whyte, 2014).

Resilience and risk in response to current adversity is influenced by factors in the child and their family and context, by what has already happened, by what is happening now, by what is anticipated or hoped for, and what eventually comes to pass. There are sensitive and critical periods in psychological and neurobiological development, periods of developmentally influenced neural plasticity, when the brain is particularly sensitive to particular kinds of experience. Exposure to or lack of those experiences has a specific and potent impact on brain development and subsequent behaviour (Knudsen, 2004; Schore, 2015).

[1] Lexico (Oxford), en.oxforddictionaries.com/definition/hope, accessed 20 January 2019

Child development in itself implies the passage of time: "Growing and becoming more mature, advanced, or elaborate",[2] or "the act or process of creating something over a period of time".[3] It is a period of ongoing, rapid, formative changes that conceptually includes both the current and anticipated stage of the child who will become an adult. In 1950, Erik and Joan Erikson summarised the psychosocial tasks of each developmental period as the eight 'ages of man'. When they were over 80 themselves, a ninth stage was added (Erikson, 1993; Erikson & Erikson, 1998). These are summarised in Table 3.1. The early stages are most relevant here.

Table 3.1: Erikson – Stages of Psychosocial Development

Stage	Approximate age	Psychosocial task
1	Infancy 0–2 years	Trust vs Mistrust
2	Toddlerhood 2–4 years	Autonomy vs Shame/Doubt
3	Early childhood 5–8 years	Initiative vs Guilt
4	Middle childhood 9–12 years	Industry vs Inferiority
5	Adolescence 13–19 years	Identity vs Role Confusion
6	Early adulthood 20–39 years	Intimacy vs Isolation
7	Middle adulthood 40–59 years	Generativity vs Stagnation
8	Late adulthood 60–79 years	Ego Integrity vs Despair
9	Very old age	Gero-transcendence

Source: Adapted from Erikson, 1993, and Erikson & Erikson, 1998.

Despite criticisms that this theory is based on white, heterosexual and culturally specific norms, it continues to be widely applied (Kropf & Greene, 2017), including in relation to refugee children (Lustig, 2010). It is useful for considering the developmental impact of either deprivation and/or threat over time, such as occurs for displaced and then detained children and adolescents. For example, Erikson's fourth stage, 'Industry vs Inferiority',

[2] Lexico (Oxford), en.oxforddictionaries.com/definition/developing, accessed 20 January 2019

[3] Learner's Dictionary (Merriam-Webster), www.learnersdictionary.com/definition/development, accessed 25 May 2018

concerns middle childhood, a time when developing mastery and competence is a priority. In most cultures this is a time of formal teaching and learning, such as through engagement at school. Children detained over months or years without access to structured education miss opportunities for support in developing key language, cognitive and technological skills, and are deprived of experiences of mastery as well as peer engagement. This compounds social and academic disadvantage during subsequent resettlement.

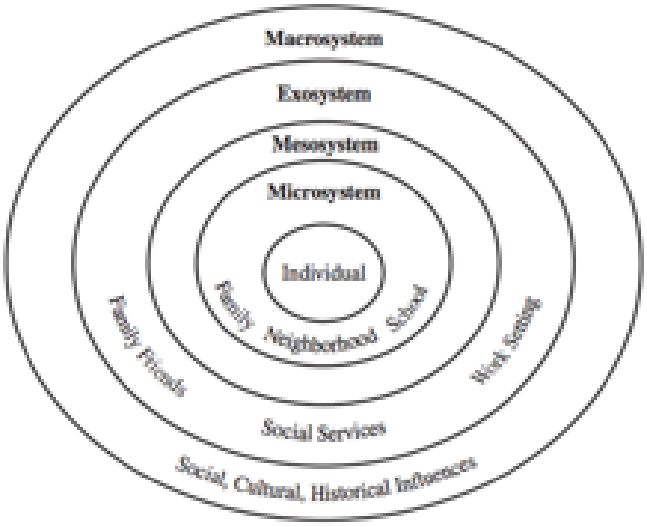
3.2 Contextual factors in development and health

Ecological systems model

Child health and development is now understood to be influenced by continuing and reciprocal interactions between the individual child, their family, and their social and cultural context. In 1977, in response to the then predominant individual and dyadic focus in research on human development, Bronfenbrenner proposed what he called an 'ecological' orientation in developmental research (Bronfenbrenner, 1977). This approach is often simplified and represented as a series of nested circles with the individual child at the centre (see Figure 3.1). He emphasised what he called 'proximal processes', that is, interactions between the individual and their immediate or 'microsystem' environment, which in most cases is the child's family and the influence of external environments on the family (Bronfenbrenner, 1986; Bronfenbrenner, 1994).

Bronfenbrenner recognised that "the ecology of human development must incorporate a life-span perspective" (Bronfenbrenner, 1977, p. 526) and that this includes transitions in the interaction between a developing individual and their environment, "as a function of the person's maturation or of events in the life cycle of others responsible for his or her care and development" (Bronfenbrenner, 1977, p. 526). He continued to review and update the model, maintaining a focus on the influence of broader contextual systems but giving increasing emphasis to the role the person plays in their own development (Rosa & Tudge, 2013; Tudge, Mokrova, Hatfield & Karnik, 2009).

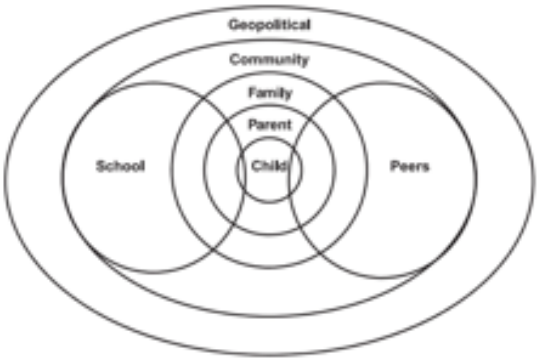
Figure 3.1: Bronfenbrenner's Ecological Systems Theory schema



Source: Adapted from Bronfenbrenner, 1977 and 1992.

Sameroff (2010) further articulated Bronfenbrenner's contribution, refining the original 'concentric' depiction and renaming the elements (see Figure 3.2) to specifically identify that children have multiple 'microsystemic' influences on their psychological and social development, including in institutional settings such as school. Sameroff emphasises transactional processes whereby the development of the child "is a product of the continuous dynamic interactions of the child and the experience provided by his or her social settings" (Sameroff, 2010, p.16).

Figure 3.2: Socio-ecological model of context



Source: Sameroff, 2010, p. 13. Reproduced with permission.

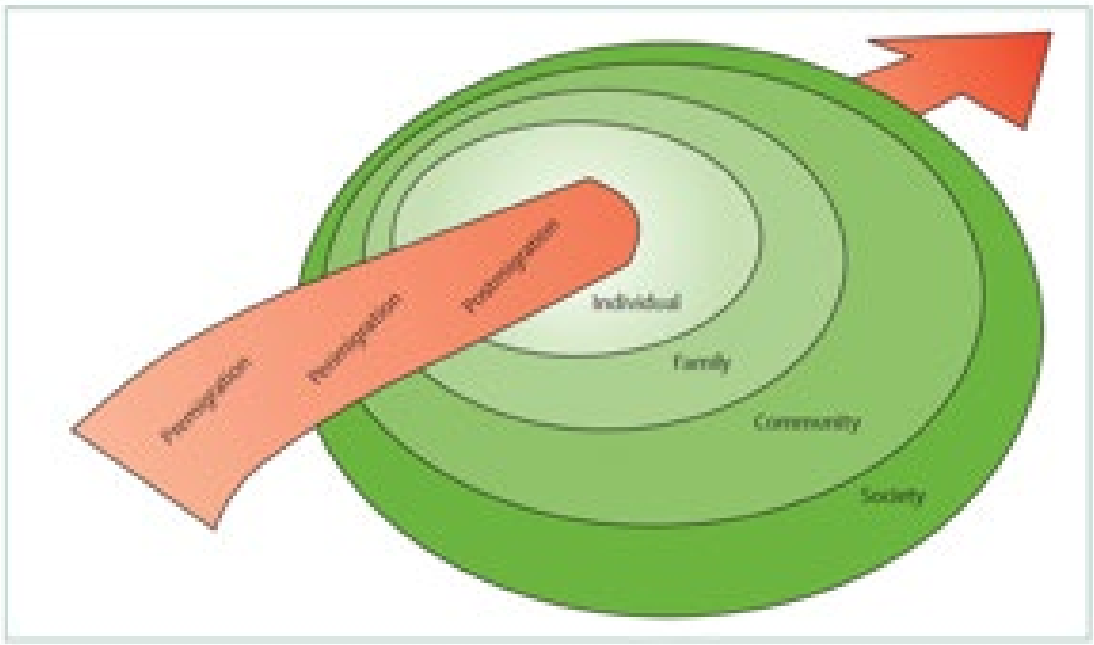
Sameroff refers to, but does not explore in detail, the importance of social and cultural systems in development. Rogoff describes it this way: "… people develop as participants in cultural communities. Their development can be understood only in light of the cultural practices and circumstances of their communities – which also change" (Rogoff, 2003, pp. 3-4). Sameroff references the work of ecocultural theorists such as Rogoff and Weisner to highlight the importance of daily activities and routines in making meaning of and for the child within the family culture (Weisner, 2002; Rogoff, 2003). Family, cultural and community routines are disrupted by forced displacement, increasing the risk of chaotic experiences for children (Lustig, 2010). For people detained after arrival, everyday life is dominated by the rigidity of externally imposed, intrusive institutional routines and contact with the involuntary community created by detention. For children without access to schooling or external activities, this form of everyday life effectively replaces the microenvironments of school and peers.

The ecological framework has been applied and adapted to consider a range of circumstances, including refugee children (Williams, 2010; Reed, Fazel, Jones, Panter-Brick & Stein, 2012). A recent systematic review of mental health in refugee children incorporates a 'chronological dimension' into the ecological framework to represent stages of the refugee journey (Reed et al., 2012) (see Figure 3.3).

Bronfenbrenner (Figure 3.1) did not include an international perspective in his initial schema, Sameroff (Figure 3.2) identifies the 'macrosystem' as the geopolitical sphere of influence, and Reed et al (Figure 3.3) include the temporal dimension in relation to displaced children.

The schema and subsequent modifications of the ecological model proposed by Bronfenbrenner provide a useful framework for considering the multiple disruptions to a child's development and experience associated with forced displacement, flight and, in particular, post-arrival detention. This framework is reconsidered in Chapter 8 as a way to illustrate the impacts of immigration detention on displaced children.

Figure 3.3: Ecological and chronological determinants of mental health in forcibly displaced children



Source: Reed et al., 2012, p. 258. Reproduced with permission.

Biopsychosocial model

In 1977, around the time that Bronfenbrenner was developing his initial version of the ecological model, Engel, similarly influenced by systems theory, described the prevailing biomedical model of disease and medical intervention as inadequate, saying "it leaves no room for the social, psychological and behavioral dimensions of illness" (Engel, 1977, p. 135). As an alternative he proposed the 'biopsychosocial' model, which can be seen as a precursor to the now established epidemiological focus on the social determinants of health. He wrote predominantly about the application of this approach to understanding and treating illness in individual patients, advancing the idea that "the model serves to counteract the often wasteful reductionist pursuit of what often prove to be trivial rather than crucial determinants of illness" (Engel, 1980, p. 543). Reviews of the biopsychosocial model 25 and 40 years later have maintained the primary focus on application of the model to patient care (Borrell-Carrió, Suchman & Epstein, 2004) and health service management (Wade & Halligan, 2017).

The biopsychosocial approach helps in understanding the high levels of distress and disease seen among detained children. Engel wrote, "Whether a cell or a person, every system is influenced by … its environment" (Engel, 1980, p. 537), highlighting the importance of the patient's environment in etiology and treatment of illness in individual patients. It is hard now to appreciate how challenging his assertions – that biological factors, genetic vulnerabilities and the impact of existing illness must be considered within the context of the social factors that influence health – were at the time. The biopsychosocial model is also useful in considering children's health and development, because childhood is a period when biological, psychological and social elements of life and development are inseparable.

The biopsychosocial approach also has limitations. The work informs but does not articulate the role of the clinician or public health organisations in advocacy for groups of people exposed to extreme environmental adversity. Engel did not anticipate a circumstance such as immigration detention of asylum seekers, where illness was so clearly precipitated and perpetuated, or patient care so compromised, by government policy. Nor does it specifically attend to developmental factors in vulnerability to illness and disease. Advances in multiple fields of research since Engel's publications, including in neurobiology and genetics, have informed the evolution of this approach into an 'ecobiodevelopmental framework' that includes the impact of early experience and environmental adversity on neuro-endocrine functioning, brain architecture and health vulnerabilities across the lifetime and across generations (Shonkoff et al., 2012).

Social determinants of health

The World Health Organization (WHO) established the Commission on the Social Determinants of Health in 2005, and the WHO website defines the social determinants of health as, "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems" (WHO, 2019).

There is an established relationship between how people live and disparities in health and wellbeing, and this identifies health as an issue of social justice (Marmot, Allen, Bell, Bloomer & Goldblatt, 2012). Adversity at any stage of life engenders vulnerability to both

immediate and chronic ailments through neuroendocrine, inflammatory, immune and/or vascular mechanisms (Adler & Stewart, 2010; Lupien et al., 2015). In addition, stressful living circumstances can contribute to behavioural and lifestyle changes that further raise the risk of, or perpetuate, illness (Marmot et al., 2012; Solar & Irwin, 2010). This evidence (Commission on the Social Determinants of Health, 2008; Solar & Irwin, 2010) informs much social and health policy in Australia and internationally, but a full analysis is beyond scope here.

It is acknowledged, including by the WHO, that in order to understand and address the increased health risks faced by displaced people there is a need to focus on "the societal, economic, and political programmatic factors that unquestionably affect health, but are outside the usual remit of health-care sectors" (Reed et al., 2012, p. 255). Literature on the social determinants of health in refugee populations includes a focus on the impact of post-arrival experiences but not specifically on immigration detention (Hynie, 2018; Hordyk, Hanley & Richard, 2015). Factors demonstrably associated with poor health and mental health that are directly relevant to the situation of adults and children held in immigration detention include low or no social status, being displaced, loss of social networks and support, very limited control or opportunities for agency, life in a highly stressful environment, little or no meaningful activity, limited diet and nutritional choice, and limited access to independent health and specialist medical care (Marmot et al., 2012).

Parenting and family processes in refugee families

Systems theory had a major impact on understanding family processes and therapeutic intervention with families (Cox & Paley, 2003). As a living system, the family is in constant transformation in response to family events, such as the birth of a new baby, and to external events. An extreme example is family members who are displaced, flee and are then detained. Transformations occur within family structures, family subsystems and boundaries, and roles and modes of communication in response to both 'internal' developmental stages and processes and changing 'external contexts'. As Williams writes, "in addition to other multiple losses, the family experiences a major power shift from internal control to external control over life decision-making processes" (Williams, 2010, p. 36). In addition, there is clear body of evidence that parental mental health can impact on

children's wellbeing and development in multiple domains (Halligan, Murray, Martins & Cooper, 2007; Reupert, Maybery & Kowalenko, 2013; van Santvoort, Hosman, Janssens, van Doesum, Reupert & van Loon, 2015). It is self-evident, but also demonstrated, that distress, illness and emotional and behavioural problems in children increase the distress of their parents, potentially leading to dysregulated interactions that are self-perpetuating (Barroso, Mendez, Graziano & Bagner, 2018).

There are limitations in the application of family systems theory and models of family functioning to dynamics within displaced families because these theories predominantly focus on processes within a family, rather than the impact of extreme external stressors on a family. Having said this, literature on the impact of trauma on interactions in refugee families during war and displacement is expanding to include the impact of post-settlement factors (Panter-Brick, Grimon & Eggerman, 2014; Sim, Fazel, Bowes & Gardner, 2018; Weine, Muzurovic, Kulauzovic, Besic, Lezic, Mujagic ... & Ware, 2004; van Ee, Kleber, Jongmans, Mooren & Out, 2016; Bryant et al., 2018; Sim, Bowes et al., 2018; Fegert, Diehl, Leyendecker, Hahlweg & Prayon-Blum, 2018; Lauritzen & Sivertsen, 2012). There is also a related but distinct literature on the transgenerational impact of trauma, including in resettled refugee families (Sangalang & Vang, 2017).

As an example, a large longitudinal study of refugees resettled in Australia, the Building a New Life in Australia Study (BNLA), interviewed caregivers of 694 refugee children two to three years after resettlement and found that 76–94% of this sample were doing well in terms of psychological and social adjustment (Lau et al., 2018, p. 13). The study used an ecological framework that considered and examined functioning in the individual, family, school and community domains. The study also found that pre-settlement trauma and post-migration stressors, such as financial and employment problems, were associated with parental PTSD, leading to "harsh parenting and consequent conduct, emotional, peer, and hyperactivity problems in the children" (Bryant et al., 2018, p. e256). These findings support an association between the level of post-migration stress experienced by the family and children's mental health. These families had not been in immigration detention prior to resettlement in Australia, and the authors note that, "The sampling frame did not include any current asylum applicants, and the uncertainty of asylum outcome might involve

different patterns (and potentially higher proportions of psycho-pathology) than seen in the current sample" (Bryant et al., 2018, p. e256).

There is a small additional literature on child maltreatment in refugee families (Alink, Euser, van IJzendoorn & Bakermans-Kranenburg, 2013; Chang, Rhee & Berthold, 2008; LeBrun, Hassan, Boivin, Fraser, Dufour & Lavergne, 2015; Timshel, Montgomery & Dalgaard, 2017). Generally, increased risk is associated with socioeconomic stress and/or parental mental illness, including depression, PTSD and substance abuse. The BNLA study (Bryant et al., 2018) and a qualitative study of Syrian refugee families (Sim, Fazel et al., 2018) have relevance here, demonstrating an association between parental PTSD, post-migration stressors, harsh parenting and child behavioural problems.

There is no quantitative literature specifically on the impact of detention on families. There is a small qualitative literature that includes the impact of detention on family processes (Kronick, Rousseau & Cleveland, 2015; Lauritzen & Sivertsen, 2012), and this includes papers within this PhD (Mares et al., 2002; Mares & Jureidini, 2004; Mares & Zwi, 2015). In addition to the difficulties of accessing detained families in order to undertake such research, there is the question of what might constitute adaptive family processes in the environment of immigration detention.

Childhood trauma and adversity

There is particularly strong evidence linking early childhood adversity with later health outcomes. Adverse socioeconomic and other exposures, in addition to more proximal influences such as quality of parenting, result in biomedical and neuroendocrine changes that embed disadvantage and trauma in children's bodies, influencing their lifetime health and development (Nusslock & Miller, 2016). In addition to the impact of stress and mental illness on parenting interactions, intergenerational transmission of vulnerabilities related to stress and adversity may occur through epigenetic and other biological mechanisms (Bowers & Yehuda, 2016).

Terr wrote a seminal paper about the consequences of trauma in childhood and first made the distinction between the consequences of a single unanticipated event and chronic or repeated ordeals. She defined childhood trauma as, "the mental result of one sudden,

external blow or a series of blows, rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations" (Terr, 1991, p. 11). A significant element in trauma is the experience of helplessness and loss of agency, and subjective perception of threat, rather than objective reality, determines what is experienced as traumatic. There is a subsequent argument that children experience a perceived or actual threat to their caregiver as equivalent in terms of stress to direct personal threat (Scheeringa & Zeanah, 2001). A child's capacity to understand, process, adapt to and recover from traumatic events is influenced by the nature and severity of the events, the child's individual developmental stage and capacities, and, in particular, the support available from protective adults.

A specific diagnostic category, 'developmental trauma disorder' or 'complex developmental trauma', has been proposed to better explain the cumulative impact of exposure in childhood to multiple or repeated forms of trauma. This exposure influences multiple affective and interpersonal domains during development, with consequences across the lifespan that are qualitatively different from exposure to an isolated trauma (Van der Kolk, 2005). This diagnostic category was proposed for, but not included in, DSM-5 (Bremness, 2014).

There is a significant overlap in the psychological and neurobiological literature on children exposed to trauma and the lifetime impact of childhood adversity. The latter literature originates in a large retrospective epidemiological study in the mid-1990s (Felitti et al., 1998). The Adverse Childhood Experiences (ACE) questionnaire asks retrospectively about exposure to 10 categories of adversity. These are identified as either household dysfunction (parental substance abuse, parental separation or divorce, domestic violence, family member with mental illness or imprisoned) or abuse and neglect (physical, sexual or emotional abuse, and physical or emotional neglect). The number of adversities is summed to create a cumulative stress score.

Multiple studies have identified a correlation between the ACE score and subsequent negative health and wellbeing outcomes across the life course (Anda et al., 2006). There is evidence that risk factors and adversity often co-occur and that cumulative adversities are most strongly associated with negative outcomes (Agnafors et al., 2017). A systematic

review found that co-occurring adversities associated with parental mental illness and child maltreatment were the strongest predictors of mental disorder, but there was no finding that specific adverse exposures were linked to particular psychopathologies (Kessler et al., 2010).

A Western Australian study recently reported on development of a refugee-specific composite ACE score (R-ACE), with 10 additional questions about adversity during the refugee journey (Hanes, Sung, Mutch & Cherian, 2017). The R-ACE asks about refugee status, past or current family separation, prolonged transit time (>5 years), interrupted schooling, and detention impact (a family member detained, child detained previously, child now detained), witnessing trauma and death of a nuclear family member. These 10 R-ACE items were scored alongside the 10 standard ACE questions about exposure to abuse, household adversity and neglect. Their study identified that 63% of a cohort of 2001 refugee children reported three or more R-ACE experiences, in addition to other ACEs (Hanes et.al, 2017). This approach to quantifying adverse childhood refugee experiences requires validation but is useful in highlighting the specific and additional adversities faced by refugee children.

The predominant focus of the literature on neurobiological and psychological consequences of exposure to trauma and adversity has been on children exposed to maltreatment within their families (Pollak, 2015; Shonkoff et al., 2012). It is worth considering the relevance of this literature for refugee children exposed to significant cumulative adversities external to the family but impacting on family structure, such as through parental loss, or impaired parenting because of mental illness.

Approaches to conceptualising the developmental impacts of childhood trauma and adversity have tended to study adversities in isolation from each other, such as exposure to childhood sexual abuse or bereavement. This ignores the evidence that children who are exposed to one risk factor are statistically more likely to have exposure to other adversities (Ferguson & Horwood, 2003). Enumerating the number of risks that an individual or population has been exposed to, such as with the ACE studies, usefully identifies populations of children most at risk of ongoing difficulties. A limitation is that this approach will, “fail to distinguish between distinct types of environmental experience, implicitly

assuming that all adverse experiences influence development through the same underlying mechanisms" (McLaughlin & Sheridan, 2016, p. 240).

In the cumulative-risk model, allostatic load and resulting disruptions to the Hypothalamic Pituitary Axis (HPA) and autonomic nervous system (ANS) have been identified as the central explanation for the lifetime consequences of childhood adversity (Gunnar & Hostinar, 2015). Allostatic load has been reviewed in detail elsewhere (McEwen, 2012).

McLaughlin and Sheridan propose an alternative approach to more specifically identifying the developmental processes disrupted by cumulative childhood adversity (Sheridan & McLaughlin, 2014; McLaughlin & Sheridan, 2016; McLaughlin, Sheridan & Lambert, 2014; Sheridan & McLaughlin, 2014). These authors propose a model (Figure 3.4) that conceptualises adversity along distinct dimensions of deprivation and threat. They argue that different forms of childhood stress are likely to have different impacts on children's neurobiological development and learning (McLaughlin & Sheridan, 2016).

Figure 3.4: A dimensional model of childhood adversity

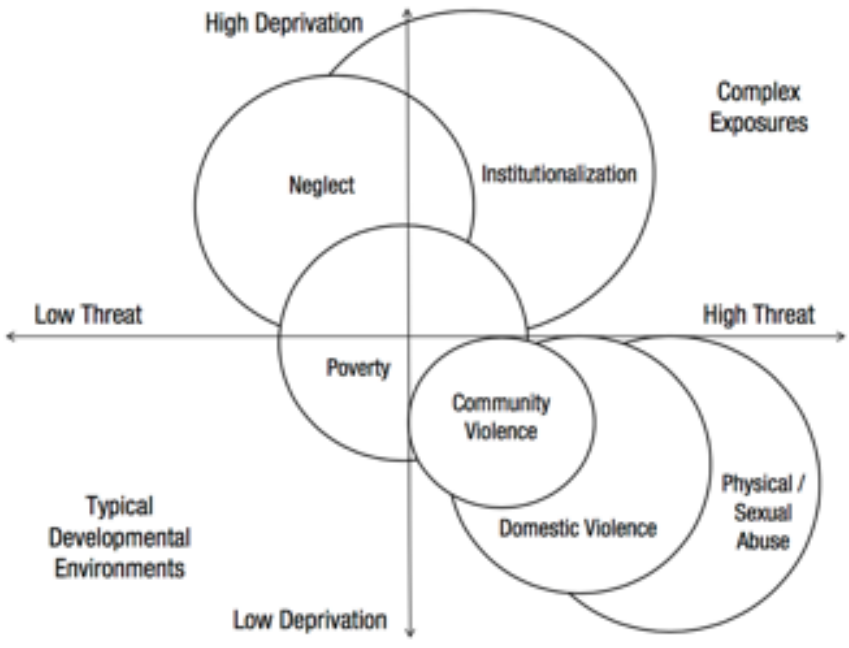


Fig. 1. A dimensional model of childhood adversity involving two central dimensions of threat and deprivation. Examples of commonly studied forms of adversity are placed along these dimensions based on the degree to which each experience typically involves threat and deprivation. Larger circles indicate greater variance in the degree to which the experience reflects the underlying dimension.

Source: McLaughlin & Sheridan, 2016, p. 241. Reproduced with permission.

Childhood adversities, considered along the dimensions of threat and deprivation, map easily onto what are called the three pillars or '3 Ps' of the Convention on the Rights of the Child (CRC) (UN, 1990). The CRC can be summarised as defining children's rights to 'Provision' (of food, shelter, and appropriate developmental opportunities), 'Protection' (from threat, harm and exploitation), and 'Participation' in their lives and decisions that influence them, including to have their views respected and considered.

3.3 Conclusion

Research with refugee children is difficult for reasons to be outlined in the next chapter. Despite this, there is a significant body of evidence on the impact on children's wellbeing of exposure to cumulative adversity during the 'refugee journey' along the dimensions of both threat and deprivation. An ecological approach focusing on contextual risk and protective factors has been used to map and address the needs of refugee children in multiple domains (Lustig, 2010; Williams, 2010; Reed et al., 2012). This overlaps with a focus on the social determinants of health.

Refugee children have increased physical health and developmental needs, including nutritional deficiencies and infections associated with poverty, war and displacement (Hanes et al., 2017; Mutch et al., 2012). They face many biological, social and cultural risks – including exposure to community violence and parental separation, loss and mental illness – and are at increased risk of physical and sexual abuse. A biopsychosocial and cultural perspective, incorporating the social and cultural structures and supports identified in the ADAPT model, ensures a wholistic approach to assessment and support (Fazel & Stein, 2002; Mutch, Cherian, Nemba, Geddes, Rutherford, Chaney & Burgner, 2012; Silove, 2005). Systematic reviews of refugee children settled in high-income and low-income countries (Fazel, Reed, Panter-Brick & Stein, 2012; Reed et al., 2012) confirm the cumulative nature of their adverse exposure. Direct exposure to threat and violence, family disruption, cumulative adversity and being unaccompanied all increase the risk that a child will suffer mental health difficulties. Many children show great resilience, particularly when they and their families are supported in resettlement, but post-migration detention, violence and uncertain migration status are particularly harmful (Fazel et al., 2012; Reed et al., 2012).

This chapter has introduced approaches to understanding the complex interaction of individual, family and contextual factors that influence the health and development of displaced children. The relevance of this to the findings of my research is considered further in Chapter 8 and is used to inform a framework for understanding the impact of immigration detention on already vulnerable children. The next chapter (Chapter 4) includes the results of a scoping literature review of studies on the immigration detention on children.

Chapter 4: Findings from scoping review

4.1 Introduction

In previous chapters the historical and political context for Australia's response to asylum seekers and an ecological and developmental approach understanding the impact of childhood adversity were established. This chapter outlines the process and findings of a scoping review of the international literature published in English between 1992, when mandatory detention of people seeking asylum by boat was introduced in Australia, and 31 May 2019, about the impact of immigration detention on children and families. The identified papers report on children detained by six countries (Australia, Canada, Hong Kong, the Netherlands, the UK and the US). The search was undertaken to enable the papers contained in the thesis to be considered in relation to the broader international literature. The identified papers are discussed in detail below.

4.2 Scoping review process

The scoping review was undertaken to answer the question: *What is the current evidence in the peer-reviewed literature about the impact of immigration detention on children and families who seek asylum?* Relevant studies were initially identified through a search of the Medline, PsychINFO, Emcare, CINAHL and Scopus databases for the period from 1 September 1994 to 30 July 2018. The initial search was then updated to 31 May 2019. Additional papers were identified at both stages of undertaking the review.

A scoping review was used to identify and map out a range of qualitative and quantitative evidence over time on this topic. The included papers present relevant qualitative or quantitative data about the impact of immigration detention on children and families. Exclusion criteria are detailed in Appendix D. This approach provides an overview of the topic as well as identifying gaps in the literature and evidence (Arksey & O'Malley, 2005; Peters et al., 2015; Tricco et al., 2016). The results provide an evidentiary context within which the publications included in the thesis can be considered and evaluated.

The scoping review process is summarised in Table 4.1. Additional data and a list of search terms are provided in Appendix D.

An iterative process undertaken in July 2018 and updated in May 2019 enabled the total of 5,303 papers identified in the search to be reduced to 127 papers. A further nine were identified while reviewing other papers. These 136 papers underwent full text review (or abstract review when full text in English was not available), to leave 22 for inclusion in the review findings.

These 22 papers (16 by other authors and six of my own) met the search criteria in that they:

- were peer reviewed or had historical significance (McCallin, 1992)
- reported data from or in relation to:
  - detained populations of children, adolescents and/or families who were displaced, refugees or seeking asylum
  - OR were follow-up studies of previously detained populations
  - OR were file audits where post-migration adversity specifically included detention
- included mental health and/or developmental outcomes or information about children.

Terminology used in the literature to describe detention facilities varies. For example, the term 'camp' is used to describe open refugee settlements, more restrictive internment camps and imprisonment in penal facilities. To enable comparison with the conditions under which asylum seekers are held by Australia, I have included only studies where the environment in which children and parents was held was identifiably restrictive, authoritarian and institutionalised, resulting in extreme limitations of movement, autonomy and activity during the period of detention.

As noted above, six papers that I authored or co-authored which are included in the thesis were identified in the process; these are included in full in Chapter 6.

Table 4.1: Summary of scoping review process, Jan 1992 to 31 May 2019

Stage of review process	Number of papers
1. Identify research question and purpose	
2. Find relevant studies	
Database	
Medline	59
PsychINFO	857
Emcare	1,700
CINHL	798
Scopus	1,893
Total	**5,303**
3. Select studies using an iterative approach	
Remove duplicates	-4,197
Initial review of title and abstract. Papers excluded if not about refugees or asylum seekers, and mental health or development	1,106 -979
Retained for full text or abstract review	127
Identified from other papers during review process	+9
Full text (or abstract review when full text unavailable)	**136**
Systematic review papers – mental health and wellbeing of displaced and/or resettled children and families	14 (Table D.2)
Review and commentary papers re immigration detention of children	16 (Table D.3)
Post-migration stressors or interventions, children and families (not detained)	34 (Table D.4)
Interventions with refugee children and families	50 (not tabulated)
Publications identified in scoping review (includes 6 papers in the thesis)	**22**
4. Chart and analyse the data from 16 papers. Include 6 papers from thesis in full in Ch 6	

4.3 Overview of findings

A total of 136 papers was identified for full review. Once the iterative process was complete, 22 papers were identified that specifically address the impact of immigration detention on children and families, include new data (rather than presenting findings of a review or commentary), and were published during the review period 1992 to 31 May 2019.

Excluded papers

I will first summarise the 114 papers that were excluded from the 136 identified in the iterative search process. These papers are useful in documenting evidence about the mental health of displaced children and families at all stages of the 'refugee journey'. They enabled, through citations, the identification of an additional nine papers otherwise excluded from the search process. This ensured that no relevant publications reporting relevant primary data had been overlooked.

Together these 114 papers provide a comprehensive overview of publications between 1992 and mid-2019 on the mental health of displaced, refugee and asylum-seeking children and parents seeking asylum or resettled in third countries. Most papers acknowledge or consider to varying degrees the challenges of researching and addressing the mental health needs of this population, specifically children. The human rights, health and social policy implications of how refugees and asylum seekers are treated during reception, processing of asylum claims, and resettlement were also frequently identified. Commentary and editorial papers include reference to non-peer reviewed or 'grey literature', in particular inquiries by local and international human rights organisations and state-based administrative bodies. Some studies address the role of health practitioners and professional bodies in service provision and advocacy. Alternatives to immigration detention of adults and children who seek asylum are occasionally mentioned (UNHCR, 2014; Hamilton, Anderson, Barnes & Dorling, 2011; Sampson & Mitchell, 2013).

Systematic review, review and commentary papers

The search process identified eight systematic review papers that considered the mental health or wellbeing of child and adolescent refugees generally (Lustig et al., 2004; Bronstein & Montgomery, 2011b; Nakeyar, Esses & Reid, 2018), or in various circumstances such as

unaccompanied (El Baba, 2018), or resettled in high-, low- and middle-income countries (Fazel et al., 2012; Reed et al., 2012; Kien, Sommer, Faustmann, Gibson, Schneider, Krczal ... & Gartlehner, 2018), or living in refugee camps (Vossoughi, Jackson, Gusler & Stone, 2018). One paper used an ecological perspective to consider the impact on caregivers and families displaced by the Syrian conflict (Miles, Narayan & Watamura, 2019). There were a further five review or commentary papers about the mental health of refugee children (Fazel & Stein, 2002; Hodes, Melisa Mendoza, Anagnostopoulos, Triantafyllou, Abdelhady, Weiss ... & Skokauskas, 2018; Rousseau, 1995), including a practitioner review (Hodes & Vostanis, 2018) and a scoping review about refugee youth in Canada (Guruge & Butt, 2015). These are listed in Appendix D, Table D.2.

There were 10 review and commentary papers specifically about, or mentioning, immigration detention of children (Kronick, Rousseau & Cleveland, 2011; Newman & Steel, 2008; Hodes, 2010; Fazel, Karunakara & Newnham, 2014; Foong, Arthur, West, Kornhaber, McLean & Cleary, 2019; Farmer, 2013; Isaacs & Triggs, 2018; Jureidini & Burnside, 2011; Sriraman, 2019; Triggs, 2018) and two that I had written or contributed to (Dudley, Steel, Mares & Newman, 2012; Mares, 2016a). In addition there were four systematic or review and commentary papers that were primarily about the mental health of adult refugees in detention or once resettled; these included evidence and findings from inquiries and grey literature about immigration detention of children (Fazel, Wheeler & Danesh, 2005; Robjant, Hassan & Katona, 2009; Silove, Austin & Steel, 2007; von Werthern, Robjant, Chui, Schon, Ottisova, Mason & Katona, 2018). These are listed in Appendix D, Table D.3.

Post-migration stressors other than immigration detention

Some resettlement stresses are faced by a majority of migrants and refugees, including lower socioeconomic status, discrimination, linguistic and cultural isolation, and difficulties with peers and educational engagement. The search identified 34 papers that present studies specifically about peri-migration and post-migration adjustment, stressors and resilience for refugee children and families, not including immigration detention. These papers are listed in Appendix D, Table D.4. They focus on the impact of specific immigration related stressors for unaccompanied or child and family asylum seekers and refugees. Stresses include: uncertainty about asylum status (Heptinstall, Sethna & Taylor, 2004);

prolonged delays and living conditions during resolution of asylum status (Goosen, Stronks & Kunst, 2014; Lauritzen & Sivertsen, 2012; Montgomery, 2010; Gormez, Kilic, Orengul, Demir, Demirlikan, Demirbas ... & Semerci, 2018; Muller, Buter, Rosner & Unterhitzenberger, 2019); threat of deportation and/or threat of or actual family separation as part of the asylum process, with some papers focusing primarily the impact of family separation due to parental deportation and detention (Brabeck, Lykes & Hunter, 2014; Lovato, Lopez, Karimli & Abrams, 2018); exposure to violence in asylum and refugee centres and camps, and the specific vulnerabilities of unaccompanied minors throughout this process (Bean, Derluyn, Eurelings-Bontekoe, Broekaert & Spinhoven, 2007a; Jakobsen, Meyer DeMott, Wentzel-Larsen & Heir, 2017; Sourander, 1998; Vervliet, Lammertyn, Broekaert & Derluyn, 2014). Many similar difficulties are faced by detained populations in addition to the direct impact of restrictive detention.

Supporting and identifying resilience is addressed specifically in four papers (Hodes, Jagdev, Chandra & Cunniff, 2008; Mitra & Hodes, 2019; Montgomery, 2010; Sleijpen, van der Aa, Mooren, Laban & Kleber, 2019). There are also papers considering child risk, parental mental health and parenting in displaced and resettled families (Alink et al., 2013; Bryant et al., 2018; Javanbakht, Rosenberg, Haddad & Arfken, 2018; LeBrun et al., 2015).

Three papers (Lau et al., 2018; Bryant et al., 2018; Zwi et al., 2018) and a related commentary (Fazel, 2018) were identified that present outcomes for refugee children and families resettled in Australia who were supported and followed post arrival; These families had never been held in Australia immigration detention facilities. Their reception and outcomes two to three years post arrival stand in marked contrast to the reception and wellbeing of children and families who arrived without documentation and were detained. These studies are useful in outlining the cumulative adversities faced by families and children who seek asylum and who are then detained.

There were another 50 papers primarily focused on interventions with refugee children and/or families. These have not been tabulated.

Summary of papers

Considered together, the 114 papers that were excluded from the scoping review present evidence about peri-migration and post-migration stressors for child refugees and asylum seekers and their families. The papers document the challenges and adversities that diverse groups of children and families face during displacement, flight and resettlment.

This is a rapidly expanding field of enquiry. The number of data, review and commentary papers on the mental health vulnerabilities and needs of displaced children and unaccompanied minors has risen significantly in recent years. This may be in response to increasing numbers of people displaced, the large influx of refugees into Europe (Hodes et al., 2018; Kien et al., 2018) and the crisis on the border of the US and Mexico (Sriraman, 2019; Wood, 2018). Notably, half of the systematic review or review papers (seven out of 14) on the mental health of refugee children, almost a third (five of 16) of the commentary papers, and more than half (19 of 34) of papers on post-migration stressors were published in 2018/19, that is, during the last 18 months of a 27-year period (see tables in Appendix D).

There is considerable diversity in the focus of these papers but, taken together, they indicate that, although all children are likely to have been exposed to adversities during displacement, some are considerably more vulnerable and less resilient than others. This may be related to individual factors such as age, gender or being unaccompanied. Child factors act in combination with the nature and degree of exposure to adversity in the generation of mental distress and illness.

Overall the literature indicates a need to focus on two areas when examining and responding to the mental health needs of displaced children and their parents. These are the cumulative nature of exposure to adversity prior to arrival in reception countries and, most relevant to this thesis, the influence of the post-migration environment in mitigating or exacerbating mental health risks for children and families. Exposure to violence, family separation and loss, followed by adverse experiences in reception countries, is identified as particularly adverse (Fazel et al., 2012; Reed et al., 2012). It is beyond the scope of this chapter to discuss these papers in further detail; however, they inform the thesis overall.

4.4 Scoping review papers

The 22 selected papers are summarised in Table 4.2. They are reported chronologically, apart from related papers on the same population sample that were not published consecutively. The papers included in the thesis are highlighted in blue. They are included in full in subsequent chapters.

In 1992 a 'review of the situation' of Vietnamese children held in detention centres in Hong Kong was prepared for Community and Family Services International in collaboration with the UNHCR and the International Catholic Child Bureau. The report (McCallin, 1992) is included here because, although it is not peer reviewed, it presents an early and very comprehensive account of the situation and consequences of immigration detention for a large sample of asylum-seeking children, including unaccompanied minors. The review was conducted between April and June 1992, when there were an estimated 18,000 Vietnamese children detained by Hong Kong. Twenty percent were unaccompanied by a parent or carer. The study process included semi-structured interviews by Vietnamese-speaking staff with 603 children (160 unaccompanied) about their current living conditions and past traumatic events. Two North American child psychiatrists contributed to the design of the survey and they also undertook in-depth clinical interviews with 56 accompanied and unaccompanied children aged nine to 18 years. At the time of the study, the children had been in detention for between nine and 42 months. Parents, teachers and other professionals involved with the children provided additional background information.

A majority of the children were identified as depressed and anxious, with presentations "characterised by sadness, lack of energy and a disinterest in what is going on around them … they ... are restless and have problems concentrating. Memories of distressing events intrude upon their thoughts" (McCallin, 1992, p. 2). Length of time in detention, prolonged uncertainty about resolution of asylum claims, and caregiving arrangements were related to the severity of symptoms, with unaccompanied children faring worst. Significantly the report notes that, "the difference is one of degree. The wellbeing of all the children deteriorates over time, regardless of caregiving arrangements" (McCallin, 1992, p. 2). Half of the most symptomatic children had experienced threats to their safety during their flight, and 52% reported threats to their safety while in detention. The study findings indicate that

pre-migration and post-migration traumatic exposures, length of time detained and unaccompanied status have a cumulative relationship to symptom severity. The report concludes that trauma experienced in detention, including exposure to violence, and particularly when combined with parental separation and loss, resulted in high levels of psychological distress in detained children (McCallin, 1992). The detailed findings of this very early qualitative study are replicated throughout the related research published in the intervening 27 years.

A decade later**,** Rothe and colleagues published two studies about a group of children and their parents who left Cuba by boat in 1994 and were detained at Guantanamo Bay for six to eight months before resettlement in the US. They used a mix of qualitative and quantitative approaches to data collection. The first paper (Rothe, Castillo-Matos & Busquets, 2002) describes the camps and the exposure of the children to "riots, violence, suicide attempts, and surprise searches in the middle of the night by armed military personnel … Sexually explicit language and overt sexual activity … poor sanitary conditions, monotonous diet … loud verbal confrontations and physical conflict" (Rothe, Castillo-Matos et al., 2002, pp. 99–100). They report quantitative data from 74 adolescents (47 male, mean age 16 years, and 27 females, mean age 15 years), who were estimated to represent 9% of the detained 13–19-year-old refugees then held in the camps. The adolescents and their parents attended a volunteer health service staffed by medical specialists from Miami, including a child psychiatrist, and can therefore be considered a symptomatic clinical sample. Data was collected and analysed from clinical interviews; the Post Traumatic Stress Disorder Reactive Index (PTSD-RI) (Pynoos, 1992); a checklist of eight symptoms indicating psychological distress; information about traumatic exposures (including parental loss, the boat journey and camp experiences); and drawings of 'the first thing that comes to mind'.

All children had severe to very severe scores on the PTSD-RI, with 94% of boys and 96% of girls scoring in the highest symptom category. A majority of children reported symptoms of distress, including frequent crying, irritability, nightmares, and sleep and appetite disturbance. Half reported the onset of enuresis. Twenty percent reported suicidal ideation and acts of self-harm. Qualitatively, 64% of boys and 89% of girls reported that the worst moments since they had left Cuba related to daily events in the camps, not experiences prior to or during the boat journey. Many reported cumulative trauma and stress before,

during and after arrival. Adolescents reported “feeling dehumanized” and being “treated like cattle”, particularly in the requirement that they wear an electronic ID bracelet at all times (Rothe, Castillo-Matos et al., 2002, p. 116).

This paper also describes the impact of the work on mental health professionals, particularly those who were Cuban Americans. They describe staff having strong feelings of empathy, identification with the circumstances of the children, and tearfulness and anger when hearing their stories. The paper describes the politicised context of the work, including the impact of public attitudes and American government policies towards Cuban refugees while they were in the camps and after transfer to Florida. The authors explain that providing clinical assistance to the children, rather than undertaking research and documentation, was their priority. The sample was not random and included data only from children attending a clinic staffed by health volunteers. These factors contributed to methodological limitations of the study. The study concludes that, given the high rates of trauma and distress related to experiences in the camps, government authorities responsible for determining refugee policy should be educated about trauma and PTSD in young refugees.

The second paper from these researchers (Rothe, Lewis, Castillo-Matos, Martinez, Busquets & Martinez, 2002) compares self-reported symptoms of PTSD using the PTSD-RI in a separate cohort of 87 Cuban children and adolescents who had an average age of 14.9 years (range six to 17 years). Data was collected at school six months after their arrival in the US. They had not previously been identified by their teachers as symptomatic. The PTSD-RI self-report data was compared with assessments of internalising and externalising behaviours using the Child Behaviour Checklist Teacher Report Form (CBCL-TRF).

A majority of these children reported moderate to severe PTSD symptoms and 57% met criteria for PTSD on the PTSD-RI, with avoidance (67%), regressive behaviours (64%), re-experiencing (60%), somatic symptoms (52%), and hyperarousal (51%) being the most commonly reported symptoms. A significant relationship was found between the number of reported stressors and the severity of PTSD symptoms. Older age and witnessing violence in the camps were moderately associated with continuing risk of PTSD. The authors conclude that the findings highlight the impact of exposure to violence pre- and post-migration and

the importance of long-term follow-up of refugee children. The children's symptoms and distress were generally unnoticed or under-reported by their teachers.

The literature incorporating observations of immigration detention of children by Australia begins in 2001 with a seminal participant–observer account from a detained Iraqi doctor, co-authored with a psychologist previously employed within the detention centre (Sultan & O'Sullivan, 2001). The authors describe the adversities associated with being detained and the cumulative impact of prolonged detention on adult detainees, with a deterioration in mental health over time.

A relatively short section on detained children indicates that many were symptomatic, including with "separation anxiety, disruptive conduct, nocturnal enuresis, sleep disturbances, nightmares and night terrors, sleepwalking, and impaired cognitive development" (Sultan & O'Sullivan, 2001, p. 595). A few children had become profoundly withdrawn, refusing to eat or drink. Sultan and O'Sullivan record that children had been exposed to violence, riots, hunger strikes and self-harm and that deteriorating parental mental health reduced the quality of parental nurture, increasing the risk of child neglect and physical abuse. The authors note the limitations of this participant account as potentially subjective and biased but conclude that "the policy of mandatory detention of asylum seekers is leading to serious psychological harm" (Sultan & O'Sullivan, 2001, p. 596).

In 2002, the first of my papers, written after assessments of families in Woomera IDC, was published (Mares et al., 2002). This was the first publication in the professional literature to specifically focus on the mental health consequences of Australia's practice of detaining children and families who arrive by boat and seek asylum. The paper is included in full in Chapter 6.

In 2003 a group of Australian paediatricians and child psychiatrists from a major children's hospital published a case report about their care of a six-year-old child, detained with his parents for months pending the outcome of their refugee application (Zwi et al., 2003, p. 322). The family's story received significant media coverage (Whitmont, 2001). The boy had become more distressed and symptomatic over time, preoccupied with imprisonment and the violence he had witnessed, with episodes of marked withdrawal, mutism and refusing to

eat or drink. He required repeated lifesaving hospitalisation for rehydration and refeeding because his condition deteriorated each time he was discharged back into detention. The paper details his case, includes two of his drawings, and highlights the clinical and ethical dilemmas for the professionals caring for him. The authors identify a conflict between their obligation to act in the child's best interests and the actions required by the policy of mandatory detention.

In 2004 two Australian papers that I co-authored were published consecutively in the same journal (Mares & Jureidini, 2004; Steel et al., 2004). The studies used different methodologies to document the mental health of adults and children in two separate groups of 10 families held in separate remote detention centres. The simultaneous publication of these papers using different methodologies to assess and document the psychiatric status of separate samples of 10 families in prolonged detention was deliberate. It enabled comparison of the two approaches and the two sets of findings, balancing the strengths and weaknesses of each approach.

The first paper, included in the thesis (Mares & Jureidini, 2004), presents a consecutive case series of 10 families (16 adults and 20 children aged 11 months to 17 years) who were referred to and assessed by a multidisciplinary child and adolescent mental health team. This paper is included in full in Chapter 6.

The second paper (Steel et al., 2004) used structured psychiatric interviews and standardised self-report measures that were administered over the phone by same-language speaking psychologists. Lifetime and current psychiatric disorders were assessed in 10 of 11 families (14 adults and 20 children aged three to 19 years) held in a remote detention centre. This study found that all the adults and children met criteria for at least one psychiatric disorder and estimated a threefold increase for adults and a 10-fold increase for children in psychiatric disorder while detained, as compared with prior to detention. All the adults and children described traumatic experiences while detained, including witnessing riots, violence between guards and detainees, fights between detainees, repeated self-harm and suicide attempts. Some children had seen their parents and friends attempt suicide. Many reported being called by number not by name and had experienced forced separation from family members. This study provided significant quantitative

confirmation about the mental health impacts of immigration detention for 10 of 11 families from one language group who were held in a remote detention centre. It is therefore an almost complete population sample. Ethical approval and legal advice were obtained to undertake the study without the knowledge of the Department of Immigration or the then detention service provider. This approach to research in a restricted setting nonetheless generated controversy (Kirmayer, Rousseau & Crépeau, 2004; Minas, 2004).

A study from the Netherlands published in 2005 (Reijneveld, de Boer, Bean & Korfker, 2005) used self-report questionnaires to compare the mental health of 69 unaccompanied adolescent asylum seekers (mean age 16 years, range 15–18 years) held in a restrictive reception setting with the mental health of a group of 53 unaccompanied adolescents housed in a routine facility where they had more autonomy. All were assessed within six months of arriving in the Netherlands. Over the time of the project, 44 incidents of violence (e.g. riots) were reported at the restricted setting compared with 13 at the routine facility. Twenty of the adolescents in the restrictive setting completed a semi-structured questionnaire about their health and feelings of safety, with more than half reporting that their health had deteriorated and that they did not feel safe.

Those housed in the restricted setting reported more emotional problems, predominantly anxiety, and significantly higher mean scores on the Hopkins Symptom Checklist (HSCL-25) (Bean, Derluyn, Eurelings-Bontekoe, Broekaert & Spinhoven, 2007b; Ventevogel, De Vries, Scholte, Shinwari, Faiz, Nassery ... & Olff, 2007) than those in the routine facility. Girls were more affected by the restrictive context than boys. Scores were also higher in the resticted group on the Reactions of Adolescents to Traumatic Stress Inventory (RATS) (Bean, Derluyn, Eurelings, Bontekoe, Broekaert & Spinhoven, 2006). The use of a comparison sample is a strength of this study, but sample size and self-report questionnaires rather than clinical assessments are acknowledged limitations. The authors conclude that restrictive reception policies aggravate the cumulative trauma already experienced by young asylum seekers and can slow or prevent their recovery.

In 2009 Lorek and colleagues (Lorek, Ehntholt, Nesbitt, Wey, Githinji, Rossor & Wickramasinghe, 2009) published results from a small pilot study on the mental and physical health difficulties of 24 children in 16 families during their detention in a British

immigration detention centre. The children were aged between three months and 17 years (median 4.7 years) and had been detained from 11 to 155 days (median 43 days). All children aged over five had lived and been educated in the United Kingdom for 18 months to years (median four years) before being detained. Seven of the children were eventually deported and 14 were granted residency.

Seven children were assessed using semi-structured clinical interviews by both a paediatrician and a psychologist, 13 by a paediatrician alone, and four by a psychologist alone. The psychologist used the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 2001) with parents to assess 11 of the children aged over three years and found that eight (73%) met criteria for psychiatric 'caseness' on the SDQ. All children reported symptoms of depression and anxiety. On self-report and parent report, sleep problems, somatic complaints, poor appetite, emotional symptoms, and behavioural difficulties were common. Six children aged seven to 11 years also completed self-report questionnaires – the Spence Children's Anxiety Scale (SCAS) (Spence, 1998), the Birleson Depression Self-Rating Scale (DSRS) (Birleson, Hudson, Buchanan & Wolff, 1987) and the Post Traumatic Stress Disorder Revised Impact of Event Scale-13 item (R-IES-13) (Smith, Perrin, Dyregrov & Yule, 2003). On these measures none of the six children scored in the normal range, with five of six children's scores indicating a high likelihood of depression, four of the six displaying anxiety at clinical levels, and one meeting the criteria for PTSD.

Paediatricians raised concerns about the children's poor nutrition, acute illness and chronic illnesses, and many children had missed routine follow-up or preventative services such as vaccinations. Eight of 14 children (57.1%) lost weight while detained. There were concerns expressed by all parents with children under four years old about their children's development or behaviour – frequent crying, withdrawal, feeding problems, incontinence, bedwetting, and other regressive and anxious behaviours. Parents were also concerned about reduced lactation and milk supply, restricted mealtimes, limited fresh food, and poor hygiene. Nine parents completed the Clinical Outcomes in Routine Evaluation (CORE) self-report measure of global distress (Barkham, Mellor-Clark, Connell & Cahill, 2006). All demonstrated high levels of generalised distress, six had actively considered suicide and two mothers were on active suicide watch.

The authors conclude that there were negative physical and mental health consequences for children after relatively short periods of detention, that the quality and continuity of health care was concerning, and that children's social and educational needs were not met. This compounded child protection concerns about neglect and risk for the children. This small study is regularly and widely cited despite its acknowledged limitations, including small sample size. It does have strengths, however, including the use of clinical assessments by paediatricians and psychologists, self-report measures, and the inclusion of data about infants.

An indirect Australian study (Deans, Boerma, Fordyce, De Souza, Palmer & Davis, 2013) used a review of medical records to analyse visits to the Royal Darwin Hospital Emergency Department (ED) in 2011 by adult and child asylum seekers held in Darwin immigration detention facilities. The authors estimate that 50% of the then immigration detainees attended the ED at least once in 2011. The most common primary diagnoses (24.3 %) were psychiatric problems. Children under 18 years made up 21.6% (n=112) of ED presentations, and the percentage of psychiatric presentations for children was 13.7%. There were 138 presentations for self-harm, and this included 15 children aged nine to 17 years, or 16.8% of children's presentations to ED. The authors conclude that there were substantial levels of psychiatric morbidity and a high prevalence of unmet health needs, and that primary health care provision within the centres was inadequate. The limitations of the methodology are acknowledged, but this study does provide confirmation of the high rates of mental illness in detained adults and children.

Four papers included in the thesis were written following my visits to the Christmas Island and Darwin immigration facilities in 2014 in my role as the Royal Australian and New Zealand College of Psychiatrists (RANZCP) consultant to the Australian Human Rights Commission (AHRC) inquiry into immigration detention of children (AHRC, 2014). Two papers (Mares & Zwi, 2015; Zwi & Mares, 2015) are participant-observer accounts written with my paediatric colleague Karen Zwi after we spent seven days on Christmas Island with the AHRC. These papers are included in full in Chapter 6.

In 2015 I was invited to write a review paper (Mares, 2016a) reflecting on the experience and accumulated evidence about the impact of Australia's immigration policies on children

and families who had arrived by boat seeking asylum. This included a summary of the then available national and international evidence about the health and mental health of detained children. The paper also provided an opportunity to consider the findings, differing methodologies and political reception of the 2004 and 2014 AHRC inquiries into immigration detention of children. This paper is included in full in Chapter 7.

Two years after the visits to Christmas Island in 2014, I published a secondary analysis of mental health data collected from adults and children during the AHRC inquiry but not previously analysed or included in the inquiry report (Mares, 2016b). In 2018 Karen Zwi and I led a comparison study of the data from children held on Christmas Island with that from a comparable sample of refugee children resettled in Australia and never detained (Zwi, Mares, Nathanson, Tay & Silove, 2018). These papers are included in full in Chapter 6 and discussed subsequently.

A Canadian group of researchers used qualitative ethnographic and narrative approaches to report on the lived experience of detained children and their parents seeking asylum in Canada**.** They published two papers on the same sample either during or after their detention. The first study (Kronick, Rousseau & Cleveland, 2015) included ethnographic participant observation by the first author, who visited the detention centre every week for six months. The authors also conducted in-depth semi-structured interviews with parents and children aged 13–18 years and play-based interviews with children aged six to 12 years. Twenty families were involved, 12 during and eight after their time detained. The families included 35 children aged 0-20 years. The mean time detained was 56.4 days. The authors conclude that, even when detention was brief, it is a "frightening experience of deprivation that leaves children feeling criminalized and helpless" (Kronick et al., 2015, p. 287). Family separation was common, with fathers often held in other facilities. Children remained symptomatic even after release. The authors conclude that children should be protected from detention and forced separation from their parents.

The second study with the same sample of families (Kronick, Rousseau & Cleveland, 2018) involved a process of narrative enquiry and analysis to understand detained children's experiences. They invited 10 children from eight families who were aged three to 13 years to create worlds about detention using sand trays and to tell stories about what they had

created (Homeyer & Sweeney, 2016). Four children created 'sand tray worlds' of the time they were detained and six created worlds of the time after release from detention. In-depth family interviews were conducted with all families, and these provided the children's narratives with autobiographical context. Children created and enacted both autobiographical and imaginary events.

Analysis of the children's 'worlds' identified three broad themes. The first was 'confinement and surveillance'. The authors considered elements of the stories that included fences, barriers, stories of capture, confinement and separations to indicate re-enactments and retelling of the experience of incarceration and other traumatic life experiences. The second theme was 'loss of protection'. Here the authors describe the sand tray worlds as including threats and dangers, sometimes from human figures and sometimes from dangerous animals, as well as mixed feelings about authority figures, such as police, who were expected to offer protection. The authors interpret these stories as indicating the children's awareness of vulnerability and loss of protection while at the same time expressing hopes that migration would improve their lives. The third theme was 'human violence', both imagined and autobiographical, "allowing worries and experiences of violence to be made visible to researchers and parents" (Kronick et al., 2018, p. 431). Some children were able to position themselves not as victims but as agents and actors, to incorporate violence flexibly in the stories, and to report alternative outcomes. In contrast, several children had their worlds and narratives overtaken over by violence and destruction.

Certain everyday themes, usually present in children's play, were absent, indicating aspects of their lived experience. Missing themes included education and schooling, friendships and peers, and symbolic or magical protective forces. The authors conclude that the study enabled children to express and re-enact traumatic experiences. The study supports existing research demonstrating that detention is a significant stressor and that "The gravity of the detention experience for these children is reinforced by the absence of stories of normality" (Kronick et al., 2018, p. 435).

The authors propose that this qualitative approach to research with detained children has therapeutic potential and is a culturally safe and ethical approach to research with this population. They identify that future research also needs to examine interactions between

researchers and participants, including the 'co-creation' of narratives. The absence of a control group is a limitation. They conclude: "The failure to protect children's right to health, and to education in detention, combined with children's own views of the stress of detention, provide evidence that detention is never in a child's best interests" (Kronick et al., 2018, p. 435).

The themes identified in these rich qualitative studies from Canada are echoed in part by a much smaller Australian paper (Lenette, Karan, Chrysostomou & Athanasopoulos, 2017) that offers secondary thematic analysis of two drawings by asylum-seeking children detained in Australia. One drawing by a 14-year-old boy had been published in the AHRC Report (AHRC, 2014). The other, by a child whose age is unknown, had been printed in a prominent Australian newspaper. The first drawing contrasts the confinement of children behind a high fence with the perceived freedom and happiness of children represented playing and smiling outside. The second depicts children in individual cages even within the detention centre and includes the words "we are in pne [pain?], we are in cage, we are in jail" (Lenette et al., 2017, p. 50). Both drawings demonstrate the confinement of the children, their sadness, suffering and isolation. The authors conclude: "Based on the themes apparent in asylum seeker children's drawings, it would be hard to argue that their best interest is enshrined in the implementation of Australia's detention policies" (Lenette et al., 2017, p. 56).

A 2017 paper by two mental health professionals previously employed with Australian detention facilities describes the environment and impact on children and families held in facilities designated as 'alternate places of detention' (APOD) (Essex & Govintharajah, 2017). The paper highlights the many difficulties faced and the similar impacts of being held in these so-called alternatives, which, despite their nomenclature, were closed and restricted facilities. There is a focus on the impact of being held in these facilities on parenting and child protection and on the clinical and ethical issues raised for health professionals. The authors conclude that, "While APODs offered a number of superficial improvements to offshore and other detention environments, mediating some harm, they quickly became damaging; APODs were far from benign and should not be considered as an alternative to immigration detention" (Essex & Govintharajah, 2017, p. 527). The authors conclude that all

forms of held detention should be abandoned, writing that "A 'kinder' version of systematic abuse is systematic abuse no less" (Essex & Govintharajah, 2017, p. 527).

A recent UK study, published in 2018 (Ehntholt et al., 2018), reports on 35 unaccompanied minors, 21 male and 14 female, who had their age disputed on arrival to seek asylum in the UK and were initially detained in adult facilities. The mean period of detention had been 22.8 days (SD 21 days) and they were assessed on average 37.5 months (SD 11 months) after release and resettlement. The adolescents had been aged between 13 and 17 years (SD 0.93 years) at the time of detention.

The study used the diagnostic clinical interview for DSM-IV (SCID-IV) for PTSD and Major Depressive Disorder (MDD) (First, Spitzer, Gibbon & Williams, 1997) to assess whether participants fulfilled the criteria for diagnoses of PTSD and/or depression. They also completed various self-report measures – the Detention Experiences Checklist UK version (DEC-UK) (Steel et al., 2006), the Stressful Life Events Questionnaire (SLE), and the Reactions of Adolescents to Traumatic Stress Questionnaire (RATS) (Bean et al., 2006).

All participants reported multiple stressful life events prior to detention, including assaults and bereavement, and many distressing experiences while held in adult facilities. This included forced searches, aggression from officers, violence between detainees or between officers and detainees, and self-harm by detainees. Many reported that their most distressing experiences related not to pre-migration events but to their age dispute and subsequent detention in adult facilities. The authors conclude that for most participants the timing and content of their intrusive memories identified the age dispute and detention experiences as causal in precipitating PTSD symptoms. The study findings are summarised to indicate that, at an average of three years after being detained, severe and chronic mental health difficulties were identified in 89% of the young asylum seekers. The most common diagnoses were co-morbid PTSD and Major Depressive Disorder (MDD) or PTSD alone. The paper does not compare these very high rates of mental illness with a community sample but notes a study that identified psychiatric disorder in 41% of unaccompanied young asylum seekers shortly after their arrival in Norway (Jakobsen et al., 2017). The authors suggest that this comparison supports the probability that the age dispute and subsequent

detention in adult facilities was a significant contribution to the high rates of chronic mental illness in their sample, three years after resettlement in the UK.

A paper by Hanes and colleagues published online in March 2019 (Hanes, Chee, Mutch & Cherian, 2019) reports on an audit of the health records for asylum seekers aged under 16 who were new patients seen by the West Australian Refugee Health Service between July 2012 and June 2016. The audit included a data from multidisciplinary paediatric assessments, health records and hospital admissions for 110 children with a mean age of six years (SD 4.72 years). Demographics, adverse experiences using the ACE (Anda et al., 2006) and the R-ACE (Hanes et al., 2017) were documented, in addition to health status. All children were recorded to have had multiple adverse exposures, including witnessing violence and death, and 97.2% had been in immigration detention (mean length of detention was seven months). A third of the children were detained at the time of the health assessment. Access to school had been interrupted for 89.2%, particularly while held in detention, and there were frequent reports of limited access to health assessment and care. The children had all been assessed by paediatricians. The most common identified health concerns were malnutrition in 56% of the sample, dental caries in 53.6% and vitamin D deficiency in almost 50%. The study found 'acute psychosocial concerns' in over half of all children and parents, but unfortunately no specific mental health data from screening or assessment was reported, despite the identified adverse exposure and mental health risks in this sample. The authors emphasise the adverse impact of 'held detention' on the children's health and wellbeing and highlight "the complex and serious nature of health needs of this disparate and highly vulnerable cohort of children, adolescents and families" (Hanes et al., 2019, p. 6). This is an important study because it confirms the high levels of adversity experienced by children who seek asylum, including while they are detained. Unfortunately, it also evidences a lack of specific attention to mental health screening and mental health data collection even when a cohort of detained or previously detained children has been identified.

A recent paper (MacLean, Agyeman, Walther, Singer, Baranowski & Katz, 2019) describes results from a cross-sectional study of families held in an unspecified US immigration detention centre in mid-2018. The families were predominantly from Honduras (50%), El Salvador (23%) and Guatemala (22%) and had been detained between one and 44 days, an

average of nine days (SD 6). The study obtained SDQ (Goodman, 2001) results completed by the mothers of 425 children aged four to 17 years. Also, 150 of the children aged between nine and 17 years completed the PTSD-RI (Pynoos, 1992). The strengths of this study are the size of the sample and the inclusion of standardised parent and child report measures. A limitation of this study, as in other studies discussed, is the cross-sectional sampling of what the authors identify as a convenience sample.

The children had rates of emotional and behavioural difficulties and PTSD significantly higher than for children in primary care in the US and also higher than for Spanish-speaking Latin American children in the US who were not detained. The rate of high total difficulty scores on the SDQ in the study sample was 10%, double rates in the general population, and post-traumatic symptoms were identified in 17% of the 9–17-year-olds using the PTSD-RI. This is more than 3.5 times the lifetime prevalence of PTSD in adolescents in the US. Almost half of all detained children who had previously been separated from their mothers had emotional problems in the high range, 49% compared with 29% of those never separated, with total problems scores also higher at 15% compared with 9% in the 'never separated' group. Younger children, aged four to eight years, had higher rates of conduct problems (15%), hyperactivity (14%) and total difficulties than children aged nine to 17 years. It is significant that 98% of children's scores on the prosocial scale were within the normal range. Overall the authors conclude that, "44% of children presented with symptoms that fell within the 'abnormal' range on at least one of the SDQ subscales or a probable PTSD diagnosis" (MacLean et al., 2019, p. 305). While the study is cross-sectional, the authors suggest that these children are likely to have been exposed to trauma in their countries of origin and during migration, and that detention in the US and reduced access to mental health care would have adverse developmental consequences.

4.5 Conclusion

A number of things became clear in undertaking this scoping review of studies published between 1992 and 31 May 2019 on children detained by six countries (Australia, Canada, Hong Kong, the Netherlands and the US). There were 16 papers identified, 22 with my own included, that provide data about the environment and experience of immigration detention and the wellbeing of children and parents who have sought asylum in Western

countries and have been detained. The six papers included in the thesis are listed chronologically to indicate their historical relationship to the other literature; these are included in full in the next chapter.

Thirteen of the 16 papers (those not included in the thesis) report qualitatively on the environment and experiences of detention (McCallin, 1992; Sultan & O'Sullivan, 2001; Zwi et al., 2003; Essex & Govintharajah, 2017; Kronick et al., 2015, 2018) and/or provide quantitative mental health data from children and families during or after their detention (Ehntholt et al., 2018; Lorek et al., 2009; Reijneveld et al., 2005; Rothe, Castillo-Matos et al., 2002; Rothe, Lewis et al., 2002; Steel, Momartin et al., 2004; MacLean et al., 2019). Two papers provide confirmatory data in the form of retrospective file reviews (Deans et al., 2013; Hanes et al., 2019), and one is a secondary analysis of children's drawings that were publicly available (Lenette et al., 2017).

In general, these 16 studies involve small cross-sectional samples using a mix of quantitative and qualitative methodologies and a range of self-report and parent report measures. The voices and experience of detained children appear in three papers through the inclusion of children's drawings and words (Zwi et.al., 2003), and narrative and thematic analysis of drawings and play (Kronick et al., 2018; Lenette et al., 2017). There were only two papers by other authors that provided information about detained families with infants and children aged under three years old (Kronick et al., 2015; Lorek et al., 2009).

The scoping review identified an equivalent number of systematic reviews and review and commentary papers about the mental health of refugee and asylum-seeking children, including two that I had authored or co-authored. There is a large and rapidly expanding body of evidence about the impact of immigration detention on the mental health of adults, and on the cumulative impact of general post-migration adversities for children and families, including delays in processing asylum claims, family separation, uncertain visa status and threats of deportation.

Despite the acknowledged limitations of studies published between 1992 and May 2019 as identified in this review, and considerable diversity in the pre- and peri-migration experiences of displaced children and families, there is an overall consistency in the findings

and conclusions. Displaced children are likely to have been exposed to trauma and adversity at all stages of the refugee journey. Rates of identified psychopathology in detained children varied from 44% in the large US study (MacLean et al., 2019) to 100% in the Australian sample of 10 families (Steel, Momartin et al., 2004), with the majority of quantitative studies identifying mental illness in at least 70% of their sample. Detained children and adults have rates of psychological distress significantly higher than in community samples and higher than refugee children held in less restrictive circumstances (Reijneveld et al., 2005). Despite the cross-sectional nature of most studies, there is evidence that the experience of immigration detention itself contributes to a worsening of distress in already vulnerable children (Ehntholt et al., 2018; Steel, Momartin et al., 2004). Qualitative studies confirm the adversities associated with immigration detention (Kronick et al., 2015; McCallin, 1992). Several studies showed that, even after resettlement, those who had been detained had persisting distress and poorer mental health as compared with people never detained (Ehntholt et al., 2018; Rothe, Lewis et al., 2002).

All of the studies noted the vulnerability of children in immigration detention, especially unaccompanied children. Significant concerns about physical health and development in detained children were reported in four of the papers (Hanes et al., 2019; Lorek et al., 2009; Zwi et al., 2003; Sultan & O'Sullivan, 2001). Eight of the 16 papers specifically refer to immigration detention of children as a breach of the detaining state's human rights obligations, in particular 'the best interests of the child' as a guiding principle, as outlined in the CRC (UN, 1990). Some authors address the ethical and policy implications of the findings. The limitations of the studies and the associated challenges of undertaking clinical and research work with detained children and families, the need for further studies and more appropriate approaches to data collection and therapeutic intervention were frequently emphasised.

This literature review completes the process of establishing a context for the research and the publications that form the heart of this thesis. The next chapter outlines the methods and methodological approaches used in the work.

Table 4.2: Scoping review papers for analysis

(Papers included in the thesis are indicated in blue)

No	Reference	Detained or post detention	Sample	Method
1	McCallin, M. (1992). *Living in detention: a review of the psychological well-being of Vietnamese children in the Hong Kong detention centers.* International Catholic Child Bureau (not peer reviewed)	Closed detention in Hong Kong 9–42 months	603 Vietnamese children	56 in-depth interviews with adolescents 603 questionnaires completed with children by Vietnamese-speaking staff
2	Sultan, A. & O'Sullivan, K. (2001). Psychological disturbances in asylum seekers held in long term detention: A participant-observer account. *Medical Journal of Australia,* 175(11-12), 593-596.	Detained by Australia	Detained Iraqi doctor and psychologist employed within the IC+DC	Participant observer account Conditions in detention and observations of adults and children
3	Rothe, E. M., Castillo-Matos, H. & Busquets, R. (2002). Posttraumatic stress symptoms in Cuban adolescent refugees during camp confinement. *Adolescent Psychiatry*, 26, 97.	Detained 6–8 months by US	74 13–19-year-old Cuban asylum seekers presenting to volunteer CAMH Service in the camp	Checklist of 8 symptoms of psychological distress – PTSD-RI

No	Reference	Detained or post detention	Sample	Method
4	Rothe, E. M., Lewis, J., Castillo-Matos, H., Martinez, O., Busquets, R. & Martinez, I. (2002). Posttraumatic stress disorder among Cuban children and adolescents after release from a refugee camp. *Psychiatric Services, 53*(8), 970-976.	4–6 months post detention by USA	87 children aged 6–17 years (average 14.9 years)	Self-reported symptoms of PTSD-RI Teacher report CBCL
5	Mares, S., Newman, L., Dudley, M. & Gale, F. (2002). Seeking refuge, losing hope: Parents and children in immigration detention. *Australasian Psychiatry, 10*(2), 91-96.	Detained by Australia	521 children then detained by Australia at time of writing Paper reports on observations in 2 IDC. Vignette 1: couple with 5-month-old infant and 2-year-old, detained 9 months Vignette 2: Couple with 3-year-old and 2 adolescent children, detained > 9 months	Modified participant observations 2 clinical vignettes Inclusion of 3 children's drawings
6	Zwi, K. J., Herzberg, B., Dossetor, D. & Field, J. (2003). A child in detention: Dilemmas faced by health professionals. *Medical Journal of Australia, 179*(6), 319-322.	Detained by Australia	Case report of a 6-year-old boy detained with family for over 14 months	Case report of a 6-year-old boy Inclusion of 2 drawings

No	Reference	Detained or post detention	Sample	Method
7	Mares, S. & Jureidini, J. (2004). Psychiatric assessment of children and families in immigration detention–clinical, administrative and ethical issues. *Australian and New Zealand Journal of Public Health, 28*(6), 520-526.	Detained by Australia for 12–18 months	Clinical sample referred to and assessed by Child and Adolescent Mental Health Service (CAMHS) 10 families 16 adults Range 20 children aged 11 months to 17 years 10 children under 5 years	In depth multidisciplinary assessment by CAMHS team Consensus diagnosis Vignettes
8	Steel, Z., Momartin, S., Bateman, C., Hafshejani, A., Silove, D. M., Everson, N., ... Mares, S. (2004). Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia. *Australian and New Zealand Journal of Public Health, 28*(6), 527-536.	Detained over 2 years	10 families from same ethnic background 10/11 families held in the IDC 14 adults 20 children aged 3–19 years	Structured psychiatric interviews Demographics Detention experiences checklist Detention symptoms checklist K-SADS-PL SCID-IV Parenting questionnaire

No	Reference	Detained or post detention	Sample	Method
9	Reijneveld, S. A., De Boer, J. B., Bean, T. & Korfker, D. G. (2005). Unaccompanied adolescents seeking asylum: Poorer mental health under a restrictive reception. *Journal of Nervous and Mental Disease, 193*(11), 759-761.	UAM held in a restricted setting in the Netherlands	69 (restricted) 16.1 years (0.7 SD) years 53 (open)16.4 years (1.1SD) years	Hopkins Symptom Checklist RATS
10	Lorek, A., Ehntholt, K., Nesbitt, A., Wey, E., Githinji, C., Rossor, E. & Wickramasinghe, R. (2009). The mental and physical health difficulties of children held within a British immigration detention center: A pilot study. *Child Abuse & Neglect, 33*(9), 573-585.	Detained in UK 11–155 days (median 43) days	14 children aged over 5 years Had lived and been educated in England for 1.5–9 (median 4) years 9 adults	Semi-structured interview with psychologist and/or paediatrician 6 children (aged 7–11) completed the DSRS and the SCAS & DSRS PTSD measure 11 parents – SDQ for children 9 adults – CORE
11	Deans, A. K., Boerma, C. J., Fordyce, J., De Souza, M., Palmer, D. J. & Davis, J. S. (2013). Use of Royal Darwin Hospital emergency department by immigration detainees in 2011. *Medical Journal of Australia, 199*(11), 776-778.	Detained by Australia and presenting to local emergency department	518 current detainees Included 112 (21.6%) children 13% psychiatric presentations, 17.9% of these included self-harm 15/189 self-harm presentations were children	Clinical record review

No	Reference	Detained or post detention	Sample	Method
12	Zwi, K. & Mares, S. (2015). Stories from unaccompanied children in immigration detention: A composite account. *J Paediatrics and Child Health, 51*(7), 658-662. doi:10.1111/jpc.12953	Detained by Australia	40 unaccompanied minors (UAM) 14–17 years old Detained 6–8 months	Participant observer account (AHRC consultant) 4 UAM statements
13	Mares, S. & Zwi, K. (2015). Sadness and fear: The experiences of children and families in remote Australian immigration detention. *Journal of Paediatrics and Child Health, 51*(7), 663-669.	Detained by Australia 6–9 months	230 people interviewed by AHRC team	Participant observer account (AHRC consultant) Children's drawings
14	Kronick, R., Rousseau, C. & Cleveland, J. (2015). Asylum-seeking children's experiences of detention in Canada: A qualitative study. *American Journal of Orthopsychiatry, 85*(3), 287-294.	Detained and post detention in Canada Mean time detained 56.4 days Range 48 hours to 330 days	20 families 12 during detention 8 after detention 35 children aged 0–20 years	Qualitative ethnography In depth semi-structured interviews with parents and children 13–18 years Play-based interviews with children aged 6–12 years Ethnographic participant observation 1 day/week for 6 months

No	Reference	Detained or post detention	Sample	Method
15	Mares, S. (2016). The mental health of children and parents detained on Christmas Island: Secondary analysis of an Australian Human Rights Commission data set. *Health & Human Rights, 18*(2), 219-232.	Detained by Australia Mean time 209.5 days (7 months) Range 90–390 SD 62.36 days)	129 children aged 0–17 (mean 7.64) years 131 adults 69 families	Secondary analysis 166 Kessler 10 (K10) & 70 SDQ Parental concerns about 48 infants
16	Zwi, K., Mares, S., Nathanson, D., Tay, A. K. & Silove, D. (2017). The impact of detention on the social–emotional wellbeing of children seeking asylum: A comparison with community-based children. *European Child & Adolescent Psychiatry*, 1-12.	Detained children vs never detained refugee children	Children aged 4–15 years 48 detained 38 community	Comparison of SDQ data from detained children vs never detained resettled refuge children
17	Essex, R. & Govintharajah, P. (2017). Mental health of children and adolescents in Australian alternate places of immigration detention. *Journal of Paediatrics and Child Health, 53*(6), 525-528.	Children and families in Alternative Places of Detention (APOD)	Observation of conditions and impact on children and families Commentary	Participant observer accounts (former mental health employees) No vignettes or data

No	Reference	Detained or post detention	Sample	Method
18	Lenette, C., Karan, P., Chrysostomou, D. & Athanasopoulos, A. (2017). What is it like living in detention? Insights from asylum seeker children's drawings. *Australian Journal of Human Rights, 23*(1), 42-60.	Detained by Australia	2 drawings made by detained children sourced from AHRC Report and local newspaper Drawing 1: 14-year-old Drawing 2: Age not specified	Secondary thematic analysis of 2 drawings by detained children, published in AHRC Report (2014) and a local newspaper
19	Kronick, R., Rousseau, C. & Cleveland, J. (2018). Refugee children's sandplay narratives in immigration detention in Canada. *European Child & Adolescent Psychiatry, 27*(4), 423-437.	Detained and post detention, Canada Mean time detained 56.4 days Range 48 hours to 330 days)	10 children from 8 families 4 during detention & 6 post detention 8 family interviews	Qualitative methodology Narrative inquiry and analysis of stories generated from children's creation of sand tray 'worlds' about the experience of immigration detention In-depth family interviews
20	Ehntholt, K. A., Trickey, D., Harris, H. J., Chambers, H., Scott, M. & Yule, W. (2018). Mental health of unaccompanied asylum-seeking adolescents previously held in British detention centers. *Clinical Child Psychology and Psychiatry, 23*(2), 238-257.	Average of 3 years post detention in UK Duration of detention 22.8 ±21.0 (4–92) days	35 unaccompanied minors (UAM)	SCID-IV RATS SLE DEC-UK

No	Reference	Detained or post detention	Sample	Method
21	Hanes, G., Chee, J., Mutch, R. & Cherian, S. (2019). Paediatric asylum seekers in Western Australia: Identification of adversity and complex needs through comprehensive refugee health assessment. *Journal of Paediatrics and Child Health.* doi:10.1111/jpc.14425	Australia Half were currently detained and 97% had been detained. Mean time in detention 7 months.	Audit of health records for 110 asylum-seeking children under 16 years with a medium age of 6 Assessed by the West Australian Refugee Health Service between 2012 and 2016	Medical records audit ACE R-ACE
22	MacLean, S. A., Agyeman, P. O., Walther, J., Singer, E. K., Baranowski, K. A. & Katz, C. L. (2019). Mental health of children held at a US immigration detention center. *Social Science & Medicine ,(230),* 303-308.	Detained in US Average period of detention of 9 (SD=6) days (1–44 days)	425 children aged 4–17 years 150 children 9–17 years	Parent report SDQ Self-reported symptoms of PTSD-RI

Chapter 5: Methodology: issues and process

5.1 Introduction

This chapter starts with an overview of the challenges and obstacles to undertaking research with detained children and adults who have sought asylum in Australia. This is followed by a description of the mixed methodological approaches used in the included papers and the thesis itself. I was authorised to enter detention facilities and meet with detained children and families as a clinician and consultant, not as a researcher. The data for these studies was collected opportunistically but deliberately during visits to immigration detention facilities between 2002 and 2014. There has been an ongoing iterative and reflective process of data collection, comparison and analysis since 2002. The aim has been to present evidence about the consequences of immigration detention for people who are detained and to consider the professional implications of the findings. The papers are included in full in the next two chapters.

5.2 Challenges of research with detained adults and children who seek asylum

There are many factors that make it difficult to undertake research with detained children and families who seek asylum. These include ethical and practical complexities related to the detention setting, the diversity and vulnerability of the population, and additional challenges related to all research with children.

Zion has written that research into the lives of vulnerable people such as detained asylum seekers requires the investigator to be "methodologically creative and ethically rigorous" (Zion, 2013b, p. 204). The vulnerability and diversity of refugees generally, and detained people and children more specifically, require heightened attention to issues of power and autonomy, of informed consent, and of inclusion and agency. There are multiple obstacles to "applying the central normative principles governing the ethics review process – the principles of beneficence, integrity, respect for persons, autonomy and justice" (Mackenzie, McDowell & Pittaway, 2007, p. 300). The obstacles are magnified in the detention environment. People are indefinitely incarcerated and in a legal and practical limbo, uncertain, unsafe, and with very high levels of mental distress. In Australia, it is an

environment where reporting and research has been specifically prohibited and at times criminalised (Steel & Silove, 2004; Dudley, 2016). Limited cross-sectional studies have been undertaken in the UK (Lorek et al., 2009), Canada (Kronick, Rousseau & Cleveland, 2015, 2018), and the US (MacLean et al., 2019; Rothe, Castillo-Matos & Busquets, 2002). In my experience in Australia consulting with detained people, planning, getting advance ethics consent and undertaking studies of any kind, particularly participatory research, has been as good as impossible. There are parallels with the ethical complexity of undertaking research in conflict situations (Zwi, Grove, Mackenzie, Pittaway, Zion, Silove & Tarantola, 2006).

These factors help to explain the opportunistic and cross-sectional nature of the work underpinning the thesis, and the relatively small number of studies identified in the scoping review (Chapter 4). The interrelated issues of consent and participation are considered below.

Socio-political context

At the broad contextual level, research with detained populations of asylum seekers is contentious. It occurs in a cross-sectoral and transdisciplinary space where public and mental health, child protection, law, politics and ethics overlap both practically and conceptually. This compounds the obstacles to undertaking research in conventional ways. The fact of participants' detention, the nature of closed immigration detention facilities and the politicised context are undeniable realities for the researcher and clinician (Newman, 2013a; Ziersch, Due, Arthurson & Loehr, 2017).

Research with children

Research with children and families is more complicated in practical and ethical ways than with adults (Morrow & Richards, 1996; Norozi & Moen, 2016). Children's social, emotional and cognitive capacities vary enormously from birth to 18 years. Child-rearing and childhood are socially and culturally constructed, with great variations in how care and protection are provided, how a socially competent adult is understood to develop, at what stage certain behaviours are considered unremarkable, and the age when children are seen as capable of managing various risks and responsibilities (Gaskins, Beeghley, Bard, Gernhardt, Liu, Teti, Thompson, Weisner & Yovsi, 2018). The complexities of children and childhood, children's

dependence and vulnerability, developmental and cultural diversities all raise concerns about their participation in research and their capacity to consent. Until relatively recently, studies tended to be *about* rather than undertaken *with* children, who have primarily seen by researchers as vulnerable to exploitation, and 'incompetent' in relation to providing consent (Morrow & Richards, 1996). There are questions about the quantitative reliability and validity of parent and self-report measures with children from diverse backgrounds, and their repeatability and relevance at different developmental stages (Block, Warr, Gibbs & Riggs, 2012; Hopkins, 2008; Due, Riggs & Augoustinos, 2014). Therefore, children's experience and intentions are often not sought or included in research even when the research directly concerns them. There are even fewer studies that include and present young children's experience and intentions. Furthermore, parental consent may be compromised by the fact of detention, and this is considered below.

Diversity

In addition to the challenges associated with research with children, the cultural and linguistic diversity and cumulative adversities faced by displaced people add another layer of complexity. Asylum seekers and refugees differ in their countries of origin, membership of ethnic, language and religious communities, in their experiences and traumatic exposures pre-displacement and during transit, in their resettlement options and circumstances, and in their individual strengths and vulnerabilities. They are likely to have faced challenges at each stage of their journey from displacement to intended safety (Ziersch et al., 2017).

The barriers to and limitations of research with refugee children have been enumerated (Block et al., 2012; Reed et al., 2012). They include: the complex ethical and practical difficulties of undertaking the research; the appropriateness and diagnostic validity of research measures in children with cumulative adversities; a focus on PTSD, rather than the much wider range of psychological distress and functional impairment that displaced children experience; the dearth of longitudinal studies; and the difficulties of finding representative samples and comparison reference groups (Ziersch et al., 2017; Block et al., 2012; Due et. al, 2014; Hopkins, 2008). In addition, exposure to prolonged adversity prior to detention, and the impossibility of including a control group, means that attribution of current disorder and distress to detention versus prior traumatic exposures is problematic.

There are also questions about the use of standardised self-report measures, primarily developed in English-speaking countries, with such a diverse population. In addition to concerns about the validity, reliability and repeatability of these tools, there are practical difficulties such as the availability of interpreters and the 'translatability' of standardised questions. In addition, there is a developing literature questioning the application and utility of western and individualised notions of trauma and loss and the focus on individual rather than collective wellbeing in research with culturally diverse people (Silove, 2013; Ziersch et al., 2017).

Access and consent

Obtaining informed consent from populations with complex vulnerabilities, such as refugees who are detained, is problematic because, to name just a few factors, there are such disparities between researchers and detained people in terms of power, privilege, autonomy, understanding and motivation (Zion, 2013b).

In Australia, access to detention centres and contact with detained people is limited by geographic, physical, legal and ethical obstacles. Barriers include the penal nature of detention facilities, which are often very remote. If access is obtained, it is hard to explain to people in desperate circumstances the distinction between a researcher and someone with the capacity to influence the outcome of their asylum claim, raising questions about the informed nature of consent, the veracity of the responses, the 'representativeness' of any sample group that agrees to participate, and lack of matched comparison groups.

Political, administrative and legal barriers and the inability to obtain consent from detaining authorities rather than from detained asylum seekers themselves also significantly limit research in immigration detention systems and with people who are detained. Restricted access to detained adults and children has been justified on the basis of national security or in the name of protecting the identities of people detained. These restrictions have the effect of preventing independent scrutiny and analysis of the impact of government policies. In Australia the practical obstacles have increased since people have been held offshore on Christmas Island or in third countries, currently Manus Island and on Nauru. The legal obstacles and politicised context were very clear when the *Australian Border Force Act* (ABF Act) was legislated in May 2015. This potentially criminalised all health and other

professionals who spoke or wrote about their contact with detained asylum seekers or the detention environment, including provision of health services (Dudley, 2016). The ABF Act was only amended to protect doctors from prosecution after a High Court challenge in September 2016, and further amendments a year later ensured protection of other health and service workers. The initial drafting and passage of this Act suggested a determination by the Australian Government to further limit scrutiny of the implementation and consequences of deterrent immigration policies.

Detained adults and children have few rights, and detention systems explicitly act to reduce their agency. These systems rarely if ever authorise or support the entry of visitors to undertake research, publish findings or participate in the process of organisational change, severely limiting participatory approaches.

In summary, there are difficulties in planning, completing and obtaining funding and ethics approval for research in this highly politicised and rapidly changing environment. If ethical and access consent is obtained, the diversity and high levels of distress and administrative and personal vulnerability of the population bring the nature of informed consent into question. Participatory approaches are limited by the closed institutional context. Methodological challenges include questions about the validity of available measures with a diverse population, the lack of control groups and the additional challenges of participatory research with children.

These factors all help explain the nature of the studies identified in the scoping review and included in the thesis. There is a predominance of small qualitative and quantitative cross-sectional or retrospective studies of children who were or had been held in immigration detention. This includes retrospective case file audits and studies on associations between mental illness and exposure to risk and adversity during displacement, flight, reception and resettlement.

5.3 Methodological approaches used in this research

Background

I did not imagine in 2002, after my initial visit to a detention facility and when the first paper was published, that immigration detention would continue into 2019, with children and

families being held on Nauru for over five years. I did not anticipate that political justification and public discourse about this and other harsh deterrent policies would have ossified rather than showing signs of abatement. Nor was it predictable that further data collection on immigration detention of children would be either possible or necessary. All visits to detention centres, in whatever capacity, provided opportunities for observation and collection of data and background information. Much of the work was undertaken and published collaboratively and has undergone subsequent reflection, re-analysis and publication. Specific methodologies, consent and approval for data collection and publication is detailed within the individual papers. Ethical advice or approval was sought and obtained in advance where possible, and the identity of individual children and adults has been protected at all times. The lived experiences of children and adults have been included as directly as possible through their words and drawings. The strengths and weaknesses of the varied methodological approaches I have used are outlined and described in more detail in Appendix E.

The underlying epistemology can best be described as 'pragmatism', which, according to Feilzer, is a research paradigm that "supports the use of a mix of different research methods as well as modes of analysis and a continuous cycle of abductive reasoning while being guided primarily by the researcher's desire to produce socially useful knowledge" (Feilzer, 2010, p. 7). She adds that this approach recognises both objective and subjective realities and "orients itself toward solving practical problems in the 'real world'" (Feilzer, 2010, p. 8). My work has occurred within the closed world of immigration detention systems. I have aimed, as Feilzer puts it, "to interrogate a particular question, theory, or phenomenon with the most appropriate research method" (Feilzer, 2010, p.13), and to heed Feilzer's warning against confusing pragmatism with expediency.[4] My intention has been to do what was possible in these complex circumstances.

There have been iterative cycles, now in their 17th year, of investigative action and reflection within a specific system. Investigation and reflection occurred during visits to

[4.] Expedient: *helpful or useful in a particular situation, but sometimes not morally acceptable*. Accessed on 21 November 2018 at dictionary.cambridge.org/dictionary/english/expedient

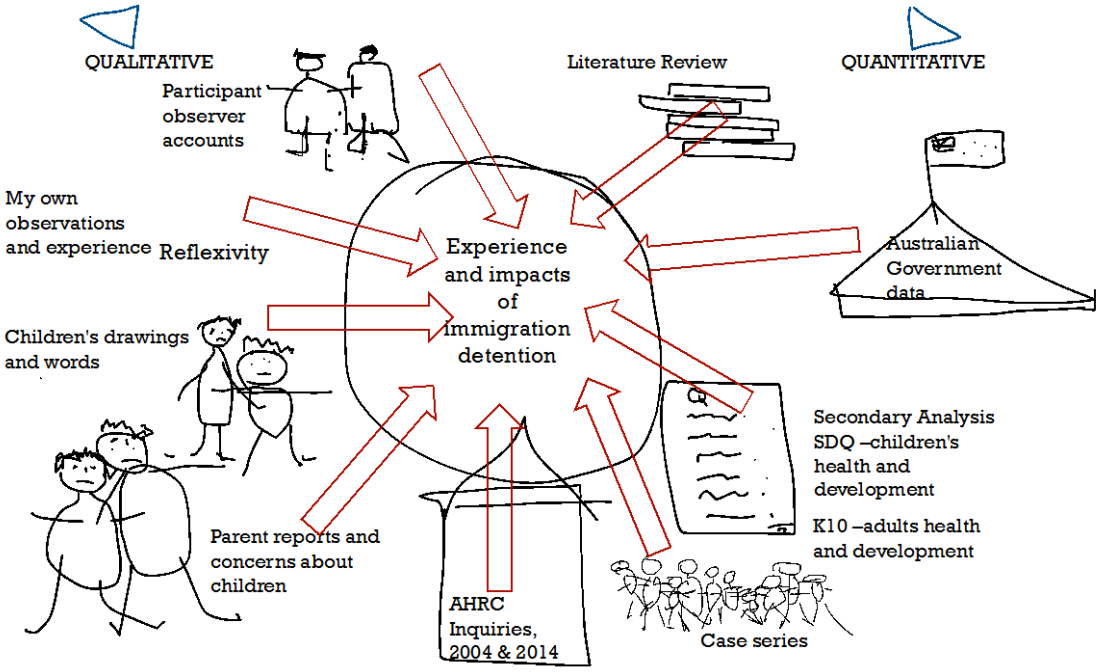
detention centres and afterwards, including in the process of writing about the collected data, and in synthesising and building a body of information based on pragmatic use of various methodological approaches. This includes the process, in this chapter, of articulating an overall methodological approach to what is in retrospect a longitudinal series of studies, or body of work, about the same system and the people held within it.

It is easy to say what the research is not. Despite the iterative process, it is not a straightforward example of action research as described by Wadsworth (2011), because of the obstacles to participation of detained adults and children described above. In addition, there is an assumption in action research that change is intended within the system being researched. Wadsworth writes, "change (or action) inevitably [original emphasis] results from the research process" (Wadsworth, 2011, p. 176). It is true that effecting change in the political and organisational system of immigration detention became a potential application of the findings because of the very evident disempowerment and distress of detained people. However, the government departments and corporate service providers involved in immigration detention and border protection services did not in any way invite or welcome research into their systems and processes, or support research with the intention of facilitating systemic change.

Overall, the diversity of approaches to data collection, analysis and reporting can be considered a strength of the work. The different sources of and approaches to gathering information and to data analysis are complementary and additive, building a cumulative picture of both the experience of immigration detention for children and parents (an emic or insider perspective), the impacts of this experience examined qualitatively and quantitatively, and the ethical and professional challenges the work raises (an etic or outsider perspective) (Killikelly, Bauer & Maercker, 2018). This 'triangulation' of information (albeit with more than three points of view) brings different methods to bear on the same research questions (Howe, 2012). The convergence of findings from multiple sources has the potential to increase the 'truth' value and validity of the findings and to enable a richer and more comprehensive description of the phenomena and the experiences under consideration. I have attempted to illustrate this in Figure 5.1.

In summary, each individual study is small and, because of access and follow-up restrictions, the work is cross-sectional. Mixed methods are used and reported in this body of work because this approach made data collection possible. The mix of qualitative and quantitative methods provides a richer description of the phenomena being analysed and reported.

Table 5.1: Sources of information



Reflexivity and autoethnography

Reflexivity, and related terms such as reflective processes and reflective practice (the latter two used more commonly in clinical than research settings), refers to a variety of processes and practices in differing contexts, all of which include an element of reflection. Reflection as a psychological and a cognitive process refers to more than a reconsideration of events, at its core indicating a turning back of the gaze, or the 'mind's eye', onto oneself. Wadsworth writes that "Life itself – and any ecology – may be thought of as depending on effective reflexive processes" (Wadsworth, 2011, p. 192). She goes on to say that "Reflexive change in an individual may result from the individual considering (reflecting on) their own action and then changing it as a result of their own autopoietic (self-organising) thought processes" (Wadsworth, 2011, p. 192). I understand this to mean that effective reflection

results in changes to the individual undertaking the study, as well as to the process and actions undertaken in the course of the study.

Harper and Thomson (2011) describe reflexivity in research practice as a slippery concept. In their terms it includes the importance of being able to stand back and reconsider the approach and actions one has taken, in order to "answer questions about how and what we can know", and they describe reflexivity as "the ability to engage critically in understanding the contribution the researcher's experiences and circumstances have had in shaping a given study (and its findings)" (Harper & Thompson, 2011, p. 6).

An extension of the notion of reflexivity is autoethnography, a research process and outcome that at face value is in stark contrast to the expectation and prioritising of objectivity common in some research methods. In addition to identifying the position from which the researcher undertakes and analyses the work, and documenting the impact of the work on the researcher, autoethnography "acknowledges and accommodates subjectivity, emotionality, and the researcher's influence on research, rather than hiding from these matters or assuming they don't exist" (Ellis, Adams & Bochner, 2011, p. 274). It often includes a "focus on the author's experience alongside data, abstract analysis, and relevant literature. This form emphasizes the procedural nature of research" (Ellis et al., 2011, p. 278). It enables 'witnessing' in relation to experiences or circumstances that are otherwise secret or hidden and "includes the ability to observe and, consequently, better testify on behalf of an event, problem, or experience" (Ellis et al., 2011, p. 280).

My 'position'

I am an educated English-speaking white woman of a certain age (and even more so in terms of age in the time since 2002). My family migrated from the UK to Australia when I was an infant. There are family stories of Huguenot refugees fleeing religious persecution in France in the 17th century, and rumours of subsequent anglicisation of European surnames. My background and my professional training and experience in medicine have doubtless shaped all aspects of the research process described, including my access to detained people, how I was perceived by them, the data I was able to collect, and the subsequent analysis, synthesis and interpretation that has been undertaken.

I started a BA, a humanities degree, and switched to a BMBS. I am trained as a medical clinician and scientist and guided in my practice by a code of medical ethics, broadly subsumed under the rubric 'first do no harm'. I undertook specialist training in general psychiatry, which emphasises both the science and art of medicine and is based on the biopsychosociocultural approach to understanding human development, wellbeing and disease. This includes respect for the rights of others and recognition of the wide variety of human experience, as well as a recognition of our interconnectedness and of the social and contextual determinants of health. My advanced training in child and family psychiatry added developmental, relational and systemic frameworks to the approaches available for analysis of human development and experience, and as elements requiring consideration in effective clinical work. These factors undoubtedly underpin my willingness to undertake initial and subsequent visits to detained families and children, the opportunities I was given and that I created to enable data collection. These factors influence how I have attempted to document and understand the data, including reflecting on it and presenting it here.

Reflexivity, including utilising my cognitive and emotional responses to the work, is a pervasive element of the individual studies underpinning the thesis and the writing of the thesis itself. Reflection on the experiences and observations made during visits to immigration detention centres and on the stories and experiences of detained adults and children provided the motivation for writing the related papers and for asking more questions. Personal reflexivity, including reflection on the process and impact of undertaking the work and of writing the thesis, is given further attention in Chapter 8.

5.4 Quantitative methods

This section introduces specific quantitative methods used in the individual studies. For more detail on the general application, strengths and limitations of these approaches see Appendix E.

Case study and case series

Case studies of immigration detention settings are reported in three papers published after visits to Woomera in 2002 (Mares et al., 2002) and to Christmas Island in 2014 (Mares & Zwi, 2015; Zwi & Mares, 2015). Brief clinical vignettes, as well as descriptions of the context,

are included. Data from 10 detained families that were comprehensively clinically assessed is presented as a case series in one paper (Mares & Jureidini, 2004).

Self-report questionnaires

Two self-report measures – the Kessler 10 (K10) and the Strengths and Difficulties Questionnaire (SDQ) – were used to collect data from detained adults and children on Christmas Island during the AHRC inquiry in 2014. The data was not analysed or included in the AHRC report. I subsequently obtained it under freedom of information legislation and undertook a secondary analysis that was published in 2016 (Mares, 2016b). More information about the K10 and SDQ is included in Appendix E.

Secondary data analysis

A secondary analysis was undertaken with data collected by the AHRC from children and adults detained on Christmas Island. The steps undertaken to protect the original participants are described in the paper; these steps include redaction of demographic details, including gender and country of origin (Mares, 2016b).

Cohort comparison or case controlled study

A cohort comparison methodology was used to compare previously published cross-sectional data from detained children held on Christmas Island (Mares, 2016b) with that from a longitudinal study of refugee children settled in the Australian community who had never been detained (Zwi, Mares et al., 2018). This study was undertaken and published collaboratively.

5.5 Qualitative methods

Narrative approaches

Narrative enquiry and associated approaches to research, which emphasise the content, construction and language of stories, have origins in humanistic and poststructural theory. They incorporate diverse theoretical and practical approaches and is described as "a multilevel, interdisciplinary field and any attempt to simplify its complexity would not do justice to the richness of approaches, theoretical understandings and unexpected findings that it has offered" (Andrews, Squire & Tamboukou, 2013, p. 13). Andrews and colleagues

(2013) provide a thorough and enlightening overview of the field of narrative research. For the purposes of this thesis I will limit myself to briefly describing the approaches used in this body of work.

Participant observation and ethnographic approaches

Narrative methods and participant observer accounts enable the inclusion of subjective/lived experience and privilege the subjectivity and agency of participants in ways that many other methodologies do not. This is important because of the obstacles to direct engagement with detained asylum seekers and the many ways in which public reporting and direct representation of their experience is controlled or distorted by political and public discourse (Klocker & Dunn, 2003; Lueck, Due & Augoustinos, 2015; Pickering, 2001).

Studies on this population are, in the main, written about rather than written with or by, the people detained, though there are a few notable exceptions in the academic literature (Sultan & O'Sullivan, 2001), the grey literature (Narulla & McCrea-Steele, 2016) and the media (Boochani, 2018). Children's voices and experience are particularly under-represented (Kohli, 2006). There are a small number of media reports specifically about detained children's drawings, and drawings have been to illustrate media stories about Australia's immigration and border protection policies (Australian Broadcasting Corporation, 2014; Fairfax Media, 2015). The absence of self-authored narratives and the limited inclusion of stories authored by asylum seekers and people with experience of immigration detention can be explained in part by difficulties of access and their own reluctance to speak in fear of reprisal. This has the effect of perpetuating notions of asylum seekers as passive, as victims, as objects of pity or fear and as 'other'.

Participant observation by people who are not detained can be understood as a form of action research, and can be distinguished from other observational studies, including some ethnographic approaches, by "the more <u>active</u> [original emphasis] aspect of participation in the lives of the people studied" (Jorgensen, 2015, p. 2). This approach makes it possible to observe and gather many forms of data that are not accessible to someone outside of the system. It is a particularly appropriate and useful method in circumstances where there are important differences in the views and experience of insiders (those who are part of the setting or group), as opposed to outsiders, and when the phenomenon is somehow

obscured or hidden from public view (Jorgensen, 2015). In my experience, immigration detention centres are such a circumstance. In addition, participant observation is said to be an appropriate method for observing everyday life and the meanings that participants make of their experiences.

A challenge in this approach involves "distinguishing and separating facts and values" (Jorgensen, 2015, p. 11), that is, the influence of the researcher-observer's own values on what is seen, recorded and understood. Critical reflection on the observations and experience is therefore a core element of this methodology and 'research reflexivity' is identified as a central methodological obligation for the participant-observer (Jorgensen, 2015).

My observations and conclusions in the papers and thesis are based on contact with families held in 10 different immigrations detention facilities. My 'participation' was partial, in that I was not detained, was not sleeping in the centres, could be let out, and sometimes was required to leave before I was ready to. I was nonetheless subject to many of the restrictions of the closed detention environment that made up the daily experience of asylum seekers. Admission into each IDC, including those classified as an APOD, involved waiting, undergoing security screening, and having everything I had with me X-rayed and manually scrutinised, including food or toys I had brought. My phone was held at the gate, except on one occasion. Occasionally I was physically searched. I was required to wear an ID badge at all times. There were prolonged periods of waiting, and the form and rhythm of my activities, where I could go and who I could talk to was determined by the institutional context. I had to recognise and accept, and was subject to, the authority of the officers, the corporate institution and the funding government department.

The process of undertaking this research and of writing and making conclusions based on observation and analysis of the circumstances of detained children and families may have influenced some elements of the way that children are detained. The findings may have had some impact on the political process and public discourse about immigration detention and did come to have this explicit aim. However, it has not been undertaken entirely with and within either the political or the immigration detention systems. It is a modified participant account and as much as possible I have included the voices, drawings and stories of

detained children and adults. My intention is and has been to reflect on the experiences, the process and the professional and ethical implications of the actions I have undertaken. In these ways, the studies can be seen as a form of opportunistic action research that uses elements of participant observation, as well as other methods.

Structured and semi-structured interviews

Structured and semi structured interviews entail a kind of 'conversation' where one person, the interviewer, has an idea of what is to be discussed and what information is to be obtained. How the information is then obtained and recorded, and what kind of information this is, varies. These interviews can be considered as a form of co-constructed narrative.

Less structured and more conversational or phenomenological interviews rely more on the rapport established between participants. They provide opportunities for people to tell their story in their own way, with the emphasis more on subjective experience and qualitative data-generation. When undertaking a psychiatric assessment interview, as was the case many times during my contact with detained adults and children, "the narrative is the primary source of information, modified by context-fitting questions, requests for elaborations, details, and examples" (Nordgaard, Sass & Parnas, 2013, p. 361). The authors go on to note that "the psychiatric interviewer cannot be merely a passive receptacle of phenomenological data but must actively participate in an interaction through which the symptoms unfold and are identified" (Nordgaard et al., 2013, p. 361). This paper identifies that the experienced psychiatric interviewer still has a purpose and outcome in mind, which includes the ability to "represent the patient's experiences and to disclose their typicality and distinctiveness" (Nordgaard et al., 2013, p. 361) so that diagnostic or other conclusions can be made. This approach emphasises the importance of including contextual, phenomenological and developmental information in any attempt to understand and communicate another person's experience.

Data collection during the 2014 AHRC inquiry included a template which I was involved in developing for the purpose of the inquiry, and consistent questions were asked by AHRC staff and consultants during interviews with older children and families. When possible, interpreters were present. Members of the AHRC inquiry team varied in their approach to these interviews, how many supplementary questions were asked and how information was

recorded, depending on the extent of their clinical or other professional experience. The methodology, including the questionnaire, and the data obtained was collated and included in the inquiry report (AHRC, 2014). De-identified data and vignettes collected during these interviews were included in papers published after visits to detention centres in 2014. Meetings and interviews with families also included the opportunity for children to draw pictures of their experiences (see below) and for parents and older children to complete self-report questionnaires, the SDQ and K10 mentioned above. More detail on the utility and psychometrics of these measures is included in the relevant papers (Mares, 2016b; Zwi, Mares et al., 2018) and in Appendix E.

Between 2002 and 2014 I undertook semi-structured interviews with detained and previously detained families and children for the purpose of clinical assessment and medico-legal report writing. The nature and conduct of these interviews were informed and determined by my professional training and experience in general, as well as by child and family psychiatry. Once the nature and purpose of the interview had been discussed, the aim was to take a conversational approach with flexibility that enabled people to tell their story in their own way, to listen empathically and responsively, and to intermittently check that I was understanding the story being told. At the same time, my responsibility was to obtain enough information to enable a psychiatric formulation and diagnosis to be developed, including assessment of current risk and protective factors for each family member. During these interviews I heard many individual and collective stories about flight, but predominantly people talked about their current experience of being detained and the impact on family and daily life, the frustrations and fears, particularly for the future.

Children's narratives

In addition to the challenges identified earlier in research with children who are detained, there are routine challenges associated with direct inclusion of children's experience in research data through qualitative and narrative approaches (Punch, 2002). Older children may communicate their experiences verbally or in written forms, but even adolescents and some adults prefer to use images as well as words to communicate. Younger children, who may not yet be 'autobiographers' or the subject of their own stories (Fernyhough, 2010, p. 4), may more readily represent and communicate their experiences in drawings, play or

behaviour rather than in words. Therefore, to incorporate children's representations of their experience into qualitative studies, images of the drawings or creations and/or verbal interpretations of these creations need to be included. This raises questions of ownership, interpretation, mutability, reproduction and other future uses of the images created by children, including parent and child consent and ownership of the created images.

Images are powerful; they can communicate more than words, and differently. Drawings created by detained children are particularly important because they enable direct communication of their experience, and also counter the longstanding prohibitions on the use of cameras and collection of images during visits to immigration detention centres. Photographic images from inside detention centres that are in the public domain are either tightly curated by the government and detention providers, taken from outside the fences, or smuggled out using mobile phones.

The thesis includes copies and discussion of images created by children as part of the 2014 AHRC inquiry that were previously published with permission in the selected papers that underpin the thesis. Drawings and quotes and a poem from unaccompanied children that were included in the selected papers are discussed in Chapter 6. These drawings were obtained in different ways and under varying circumstances. Four of the thesis papers include children's direct communications through drawings and words (Mares et al., 2002; Mares & Zwi, 2015; Steel, Mares et al., 2004; Zwi & Mares, 2015).

More information about the use, permissions and interpretation of children's drawings is included in Appendix E.

Invited editorials, opinion pieces and book chapters

Two of the works submitted for the thesis are invited editorials or opinion pieces (Mares, 2016a; Silove & Mares, 2018), and two are invited book chapters (Mares & Jureidini, 2012; Steel et al., 2004). These publications do not present primary data. They instead provide an overview of current evidence, including knowledge obtained during visits to immigration detention centres and in work with detained or formerly detained people, in order to explore the clinical, public health professional, ethical and personal implications of both the

findings and the experience of undertaking the work. These publications give contextual depth to and indicate the application of the findings in a range of settings.

5.6 Analysis

Approaches to data analysis in this thesis have varied depending on the nature of the data, and each paper includes some description of the process. For example, the case series of data from detailed clinical assessments of 10 families was used to develop consensus diagnoses for each individual, a method consistent with Spitzer's LEAD approach (an acronym for 'longitudinal evaluation of the available data') (Spitzer, 1983). Data from the 36 individuals was analysed to determine rates of mental illness in the children and adults (Mares & Jureidini, 2004) and was reported alongside detailed qualitative information about the environment and experience of living in the detention centre.

As another example, the paper reporting secondary analysis of quantitative data from children and adults held on Christmas Island includes the following description: "Descriptive analysis of socio-demographic characteristics and mental health outcomes was undertaken to assess bivariate associations between parent and child indices. Multilevel analysis based on Actor-Partner Interdependence Model (APIM) and structural equation modelling was applied to examine for dyadic associations between parent and child outcomes" (Mares, 2016b, p. 225). The qualitative data from semi-structured AHRC inquiry interviews underwent thematic content analysis before synthesis and inclusion in the resulting paper (Mares, 2016b). The quantitative data from this study was then compared with that from another sample of refugee children settled in the community and never detained. This comparison data was analysed statistically and the methods are described in the paper (Zwi, Mares et al., 2018).

Other papers included information about the experience of immigration detention, as well as the individual's or family's mental state and functioning, that was collected during interviews undertaken primarily for the purpose of psychiatric assessment. This was de-identified, analysed and reported thematically, along with de-identified vignettes and direct inclusion of participant's words, drawings and stories (Mares et al., 2002; Mares & Zwi, 2015; Zwi & Mares, 2015).

A range of analytical and statistical methods have been used in the included papers, as indicated by the nature of the data, and these are detailed in the included papers.

5.7 Data integration and synthesis

Some questions can be adequately considered only by including data from a range of sources; as Dixon-Woods and colleagues identify, this includes "studies able to overcome problems with access to sensitive or hard-to-reach settings" (Dixon-Woods, Jones, Young & Sutton, 2005, p. 45). Immigration detention facilities clearly fit this description.

There are different approaches to integrating and interpreting data of diverse kinds into a coherent set of results and conclusions. The literature generally refers to approaches to data integration from different sources in order to undertake systematic reviews (Dixon-Woods et.el., 2005; Lucas, Baird, Arai, Law & Roberts, 2007) and/or to inform policy and service development (Mays, Pope & Popay, 2005). Less has been written about data synthesis and integration within a body of research work, and particularly work that has occurred over many years.

In addition, while the thesis uses mixed methodological approaches, over time there has been an iterative and reflective process that can be likened to an informal continuous comparative analysis (Corbin & Strauss, 2008; Glaser, McCall & Simmons, 1969). Qualitative and quantitative data was collected, analysed and reported after initial visits to detained children in 2002, and then reconsidered in the light of subsequent data collection and analysis during contact with detained families between 2002 and 2018. In this way both the existing and the new data have been repeatedly reviewed, compared and integrated over time. This has enabled both an accumulation and accretion of data of different kinds, from different places and at different times, and has supported the development of findings and conclusions based on the data over time. The thesis is the final stage of this process. The information is organised thematically and the thesis has provided an opportunity for narrative synthesis, defined as "moving beyond a summary of study findings to attempt a synthesis which can generate new insights or knowledge" (Mays et al., 2005, p. S1:12).

The literature referenced above is used to describe how the variety of data collected in the papers submitted for this thesis has been drawn together in order to make findings, discuss the implications of the findings and to draw conclusions.

5.8 Conclusion

This body of work presents data collected opportunistically but deliberately with and from an extremely vulnerable population of adults and children. It was obtained during visits into immigration detention facilities in different onshore and offshore Australian locations between 2002 and 2014. Whatever their designation, the places of detention are penal institutions where my entry was authorised as a clinician, consultant or medicolegal expert, but not primarily as a researcher. This transdisciplinary collection of data has been recorded, analysed and reported over time using a range of qualitative and quantitative methods. The inclusion of qualitative and quantitative information has provided a rich and multifaceted description of the experience and consequences of immigration detention for children and families. From a research perspective, this mixed methodological approach has enabled questions to be posed and to an extent answered, with directions for further research then being identified.

There has been a continuous iterative and reflective process of data comparison and analysis, with the aim of presenting information about the experience, the impact and the multiple consequences of immigration detention for those detained, as well as applied and theoretical conclusions. The findings and conclusions are the outcome of this process. Reflection on the implications of the findings and the impact of the work is included in the original journal articles, in invited editorials and book chapters, and in the thesis.

Chapter 6: The detention environment and mental health of detained children and parents

This chapter contains six of the 10 papers that underpin the thesis. These primarily present evidence about the environment of immigration detention and the mental health and wellbeing of detained children and families. The chapter includes an additional section specifically reconsidering the drawings and words of detained children in order to highlight and privilege their experience of life in detention. The evidence presented raises questions about the role of mental health professionals and researchers in this unique and restrictive setting, and there is recognition and some mention of this in the papers. Chapter 7 includes four papers where these professional issues are the primary focus.

6.1 Papers presenting data collected during visits to detained children and families

These six papers present and analyse data collected during visits to detained children and families 12 years apart, first to a remote IDC at Woomera in South Australia in 2002 and then to IDCs and APOD on remote Christmas Island and in Darwin in 2014. Five of these primarily record and analyse data and observations of children and families in immigration detention (Mares, 2016b; Mares & Jureidini, 2004; Mares et al., 2002; Mares & Zwi, 2015; Zwi & Mares, 2015). One is a cohort comparison study, comparing data from refugee children resettled in the community with the data from detained children (Zwi, Mares et al., 2017). These papers were identified and included in the findings of the scoping review.

Paper 1

Mares, S., Newman, L., Dudley, M. & Gale, F. (2002) Seeking refuge, losing hope; Parents and children in immigration detention: *Australasian Psychiatry, 10*:2, pp. 91-96

This paper provides a witness account of my first visits with colleagues to detention facilities in January 2002. The primary focus is on experiences and interviews with de-identified children and families held in the Woomera IDC in the remote north of South Australia. The facility was closed in April 2003.

I conceived and drafted the paper in consultation with my co-authors. I was responsible for collation and integration of the contents, for submitting and responding to editorial suggestions, and for all contacts with the publisher (in summary: research design 30%, data collection 30%, writing and editing 75%). The paper is reproduced with permission.

This paper can be described as a single in-depth case report and/or a participant-observer account of a particularly unique environment (Jorgensen, 1989). We were granted access to the detention centre in order to provide expert psychiatric opinion to support legal proceedings. The visits included interviewing families about their personal experiences, daily lives and wellbeing, and direct observations of the setting, the institutional environment and the impact on people detained. It is not a conventional participant/observer account in that our entry as health professionals into the detention centre was unusual and therefore potentially disruptive to the institutional routine. However, we were subject to and observers of the authoritarian and penal aspects of the detention system, and witness to people's everyday experiences, their distress and vulnerability, including the impact on the children. These experiences, reflection on them and publication of the paper enabled us to describe and analyse a situation otherwise hidden from public view, and to consider this in the light of our individual and collective professional expertise. The experience of detained parents and children is included in de-identified case vignettes and children's drawings and words. Conclusions about the impact of immigration detention on children and families are based on these observations.

Each of us kept detailed notes during our time inside the IDC as a record of interviews with families. Reflection on the experience included a collective debrief in the days after the visits, and I made further documentation of the experience and observations. I discussed my experiences in the confidential setting of peer review and with trusted colleagues. Preparation of medicolegal reports provided opportunities to revisit the details of our visit. Preparing the paper provided further opportunities for synthesis and reflection.

This was the first publication in the international literature to focus solely on Australia's practice of detaining children and families who arrive by boat and seek asylum.

PSYCHIATRY AND SOCIETY

Seeking refuge, losing hope: parents and children in immigration detention

Sarah Mares, Louise Newman, Michael Dudley and Fran Gale

Objective: *To record observations made by the authors on a series of visits between December 2001 and March 2002 to two of Australia's immigration detention centers and to consider the mental health consequences of Australia's policy of mandatory immigration detention of asylum seekers for families and children.*

Conclusions: *Parents and children in immigration detention are often vulnerable to mental health problems before they reach Australia. Experiences in prolonged detention add to their burden of trauma, which has an impact not only on the individual adults and children, but on the family process itself. Immigration detention profoundly undermines the parental role, renders the parent impotent and leaves the child without protection or comfort in already unpredictable surroundings where basic needs for safe play and education are unmet. This potentially exposes the child to physical and emotional neglect in a degrading and hostile environment and puts children at high risk of the developmental psychopathology that follows exposure to violence and ongoing parental despair. Psychiatrists have a role in advocating for appropriate treatment of these traumatized and vulnerable parents and children.*

Key words: *asylum seekers, Australia, children, families, mental health, trauma.*

INTRODUCTION

Currently, Australia has a policy of mandatory detention of all asylum seekers who arrive without a valid visa while applications for refugee status are processed. Detainees include families and unaccompanied children, and processing can take many months or even years.[1] Recent statistics[a] show that the majority of asylum seekers who enter Australia's immigration detention system will be found to be refugees under the 1951 Convention.[2–4] In November 2001 a total of 521 children under the age of 18 were in immigration detention and 53 of these were unaccompanied minors. Ninety-four per cent of children and families were in isolated, rather than urban Immigration Detention Centres (IDCs).[1]

The IDCs are run by Australian Correctional Management (ACM), for the Department of Immigration, Multicultural and Indigenous Affairs (DIMIA). ACM is a subsidiary of the American company, Wackenhut Corporation. Medical care is provided to detainees by ACM staff. At the time of our visits, there was no information about the extent of mental health problems in this population, no access to undertake such

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a According to figures contained in DIMIA Fact Sheet 74 Unauthorised Arrivals by Boat (http://www.immi. gov.au/facts/74unauthorised.htm) a total of 8316 people arrived in Australia unlawfully by boat in the 2 year period from July 1 1999 to June 30 2001. As of 2 December 2001, 4407, or 53%, had been recognised as refugees and granted a protection visa. The final proportion may be higher since some applications are still be pending or under appeal.

screening, and no confirmed arrangements between DIMIA and state Departments of Health and Family and Community Services for provision of adequate mental health assessment and treatment for those families in need.

This is at variance with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Position Statement on the Provision of Mental Health Services to Asylum Seekers,[5] which states that all asylum seekers should be given full access to mental health services, expresses particular concern about detention of children, and states a commitment to the promotion of the mental health needs of this population and research into their mental health and mental health needs.

In 1990, Australia ratified the United Nation's Convention on the Rights of the Child. Australia's policy of detaining accompanied and unaccompanied children has been identified by Amnesty International as breaching our obligations under this Convention in several key ways.[6]

ASYLUM SEEKERS AND PSYCHIATRIC MORBIDITY

Studies of adult asylum seekers show high levels of psychiatric morbidity, particularly depression, anxiety and post-traumatic stress disorder (PTSD).[7] Children are particularly vulnerable in this environment. They may spend a significant part of their young lives deprived of adequate education and housing, and are traumatized not only through the direct effect of exposure to violence that has become inevitable in the detention environment, but as a consequence of their parent's disempowerment and despair. At sensitive and crucial periods of their development, these children are traumatized in a context where their parents are not able to offer comfort and protection. Parents, because of their own intense hopelessness and depression, may at times be the source of the child's trauma and anxiety. There is considerable literature demonstrating the impact on children of exposure to trauma and violence,[8-11] the impact of parental mental illness on social and emotional development,[12,13] and the long term developmental and health consequences of such exposure.[14,15]

THE VISITS

Access by mental health professionals to Australia's immigration centres is extremely limited. At the time of writing, repeated offers from the Faculty of Child and Adolescent Psychiatry and, more recently, Committee of Presidents of the Combined Medical Colleges to undertake screening and to work with DIMIA in the provision of appropriate mental health services to the detainee population, have met with an inconclusive response. The authors were aware of concerns about the mental health and development of children in detention. Visits to the centres occurred with the lawyers representing the families interviewed and the authors have been involved in preparation of medicolegal reports on their behalf. Our identities as mental health professionals were known to DIMIA officials in the centres before we interviewed the families described below. We were not given permission to interview unaccompanied children, or to sit in on the interviews conducted by the lawyers representing these children. Individual family members were announced to us by number not name. Interviews were held with the assistance of interpreters. In order to protect the families, the centres are not identified and family details have been altered.

The following vignettes illustrate the situation for families and children in immigration detention. We believe that the circumstances detailed are not unique to the families described, but are representative of the experience of children and families in immigration detention in Australia.

Vignette 1: "Please save my children"

A couple with a 2-year-old and a baby aged 5 months repeatedly begged, "Please take our children, find a place for them away from here. They will change to savages, not humans. He [the toddler] doesn't trust in us anymore. He can't play, he won't eat, he can't sleep well".

This family had spent nine months in detention and had recently had their application for refugee status refused. Mrs Z had her first child in the Middle East, in a normal, uncomplicated delivery and had breastfed him for 12 months. She was too distressed to talk about the second child's birth so the story came from her husband. Labor was induced after a period of four weeks enforced bed rest, under guard in a hospital several hours drive from the IDC, away from her husband and son. The child was born by caesarian section. No interpreters were present, nor was her husband. She says she did not understand or consent to the surgery and no medical explanation for it was given. She did not see her baby for some days and could not breast feed when she was returned to her. Mrs Z and her baby returned to the camp one week after delivery and were given no follow up, apart from occasional visits to the ACM nurse, who gave her panadol. Her wound continued to weep for six weeks and remains painful.

The 2-year-old's behaviour deteriorated during and after his separation from his mother. During the interview he was angry and disruptive, throwing any offered toys away, spitting at people, and attempting to eat bits of foam on the floor. He repeatedly tried to leave the room and, when successful, wandered quite far until returned by a guard. His father said: "You see his behaviour? It is because we are sad and weeping all the time. He has lost his trust in us. We came here hoping to be free but this is worse. There is a big possibility that I kill myself here. I am

a dead man, everyday I am dying slowly. What have I brought my family to?"

His wife had an air of despair and helplessness. She attempted to limit her son's behaviour but soon gave up. She initially placed the baby in her pram in the corner of the room, facing the wall, then fed her without eye contact. Her expression was sad and mask like. The infant (at a developmental stage when most babies interact socially at every opportunity), made no attempt at eye contact, made little sound or complaint, and looked profoundly sad. Ms Z's experiences associated with her younger child's birth added to her sense of hopelessness and violation. She said, "I know I love my daughter, but when I look at her I feel sad instead of happy". Mr Z was initially coherent and appropriate but became more angry and distressed as the interview progressed. At first firm with his son, he was at one point rough as he dragged him away from the door. His anger and despair about their situation and his guilt about bringing his family into the current situation were palpable. The parents' relationship was clearly under stress.

The impact of parental depression on infant and toddler development is well documented,[12] particularly in the context of other environmental stressors. The capacity of these parents to adequately meet the needs of their children is severely compromised by their own untreated depression and despair in the context of ongoing detention.

Vignette 2: "My brother doesn't know what flowers look like"

The P family have two teenage children and a son aged 3. The father and daughter cried through much of the interview and repeatedly expressed the wish to die. She said. "All the time I think about how I can kill myself. Life here has no meaning for me, all the time in my mind, over and over, how can I do it? My (younger) brother doesn't know what flowers look like. This is not a life".

The centre where this family have been detained for at least eight months was indeed totally barren, the only small area of grass and shrubs being around the ACM and DIMIA offices, an area not accessible to detainees. The compounds are barren, harsh areas of dust and stones with no shade, surrounded by two fences of razor wire. Detainees within the centre are kept in different "compounds" depending in part on the stage of their applications. A few children were seen standing in the open or hanging on the fences, moving rubbish bins from one place to another, kicking stones. There was nothing for them to do. We were told that many of the children, even up to the age of 12 are incontinent day and night, and many mattresses lay outside in the sun against the fences.

All of the P family who were old enough to do so, expressed considerable anxiety about other family members hurting themselves. Mrs P said "All they see is depression and disappointment". The teenagers had witnessed their father make a significant suicide attempt when their application for refugee status was refused after seven months of waiting. After this, he reportedly spent several days in isolation in a police cell. He did not seem to have been offered psychiatric assessment or help. He said "Even if we get our freedom, we will be mad people by then." After describing briefly the trauma and discrimination that the family had experienced before leaving their home land, he said, "Sometimes now I think our life was sweet there. Why have I brought my family to this hell?"

The adolescents are frequently tearful day and night. The younger reported being fearful of sleep, lying awake until 4 am, nightmares, then unable to wake in the mornings. She repeatedly dreamed and visualised scenes of her father being covered in blood. The older described his mood as, "Worst at sunset, when it is dusky – the weather then is like our mental situation." Both said they are tired all day with no interest or concentration, experiencing frequent, intrusive thoughts of suicide and self harm. They said they wished their father had killed them, rather than trying to kill himself. Mr P said that there was no way to describe his condition at that time and how he felt about his family. "Eight years of witnessing war and blood in my country are better than one year in this camp".

During recent protests at the center the three year old had seen officers come in anti-riot clothes and beat people with batons. He had seen people toppled by the water cannon, lying motionless on the ground. Since then he had been bedwetting again, eating poorly, clingy, crying at night, and unable to play. The drawing below (Fig. 1) was drawn by a 9-year-old child to represent her experience of this time in the camp.

Mrs P told us that her son's favorite activity used to be to watch the various trucks and tractors but, since the riots, he expressed fears of the "fire-engine", and cried at the sound of any of the vehicles that regularly drive around the camp. "I try to tell him its OK now, but how do I know that is true? They can come again, it can happen again." During the interview, he was quiet and restricted in his play and affect. He clung to his mother, said very little and did not play with a toy truck that his mother gave to him.

The rest of the family also said they had not been "mentally normal" since the riots and the fire. The older children, who were at the other end of the centre at the time, saw the smoke and thought their room was on fire. They panicked. It was "like the war, people were running everywhere, their faces were covered, it was dark, everyone was shouting and screaming".

They had seen an ACM psychologist, but had not found this helpful. He offered sleeping tablets and

Figure 1: A 9-year-old's experience of life in a detention centre.

tranquilisers, but the family were not taking them, saying "They just make us sleep all day".

Both teenagers were profoundly depressed and the younger was overtly angry. They have nothing to do all day and had had no educational opportunities for months. The English classes initially offered in the IRPC they described as "Rubbish, two hours a day of learning the alphabet with a teacher who knew less than us". When asked to draw a picture of their choice, the girl drew a weeping bird in a cage, and said, "This is not how I *feel,* it is how *I am"* [this drawing appears on front cover]. Her brother said "All I can see is the wire and us behind it" (Fig. 2).

Every member of this family is traumatized by their many months in detention. The three year old has regressed after witnessing violence, and his parents feel unable to reassure him or to protect him from further exposure to violence and chaos. The father and both adolescents have symptoms of depression and suicidality and the adolescents suffer intrusive traumatic memories of events prior to arriving in Australia, and of events occurring while in detention. These experiences add to their burden of existing trauma and loss. This is consistent with a suggested risk of re-traumatisation in adults asylum seekers in prolonged detention in Australia,[16] and evidence about the compounding of pre and post migration stressors in this group.[17]

Figure 2: "All I can see is the wire and us behind it."

DISCUSSION

As these vignettes illustrate, a direct consequence of the policy of detaining families who seek asylum in Australia, is that in the harsh penal environment of immigration detention, children are deprived of basic human rights such as adequate education, and opportunities for safe play and development. They are inevitably exposed to violence (rioting, fires, acts of self harm and suicide attempts) and to unrelieved

contact with angry, hopeless, frequently suicidal adults (often their parents as well as other detainees). Detention centre staff are sometimes threatening and insulting, reportedly calling the children "towel heads" or "little queue jumpers". One mother asked for clothes to fit herself and her children and was told "Make them out of the curtains". ACM behavioural management strategies are frequently coercive. Independently attested accounts by detainees suggest that when particular children or their families are regarded as troublemakers (e.g. youth engaging in violence and self-harm), the children have been placed in solitary confinement for extended periods.

Children in detention have the dehumanizing experience of being identified by number not name, along with their parents. They witness suicidal acts by their parents and other adults. They are housed in basic accommodation, often without privacy. They are woken in the night by detention center staff completing "musters". They may not have clothes that fit them. Despite living in a hot, stony dusty place, unrelieved by trees or grass, they may only have thongs to wear. They are unlikely to have age appropriate toys. They can only access food at set meal times unless their parents have money to buy 'snacks' often at inflated prices. They are locked in "compounds" surrounded by two fences topped with razor wire. Toilet blocks may be blood-stained and filthy, without toilet paper, or shower heads that work. Teenage girls reported needing to be escorted by parents to the toilet blocks because of harassment by other detainees. One father said, "The situation here is turning us all into savages. Whatever laws we had in our own place are breaking down here where we are treated as less than human". There have been several reports in the last year of sexual abuse of children in detention centers in Australia.[6]

Parents, already burdened by grief and guilt, are unable to fulfil their protective role or provide for their children adequately and are profoundly depressed and guilty as a consequence. This is not just material provision. More important is the difficulty of providing comfort, care and protection, and transmitting hope about the future. The inability to protect their children from their own hopelessness compounds their depression. This represents a breakdown of the parenting process and compounds the

Figure 3: Drawing by a teenager in Woomera after riots in 2001.

traumatic impact for children of living in the detention environment.

CONCLUSION

Families arriving to seek asylum in Australia have already experienced displacement, loss and, frequently, exposure to violence and war in their countries of origin. They are vulnerable, desperate and poor, with few material or psychological supports. Immigration detention profoundly undermines the parental role, rendering the parent impotent, unable to provide adequately for their child(ren)'s physical and emotional needs, in an environment where opportunities for safe play, development and education are inadequate or unavailable. Parental depression and despair leaves children without protection in an already terrifying and unpredictable place. Children are at high risk of emotional trauma since parents are unable to provide for them adequately or to shield them from further humiliation and acts of violence in a degrading, hostile and hopeless environment.

These children and their parents have no public voice and very limited access to the services and facilities that we take for granted. They are in many ways invisible and therefore dependent on others to tell of their plight and to advocate on their behalf. Lip sewing by adult detainees as a recent form of protest can be understood as a powerfully symbolic illustration of the impotence and invisibility they feel.

Psychiatrists have a clear role in the assessment and treatment of victims of trauma of whatever kind. The particular circumstances of immigration detainees in Australia, (including prolonged detention in isolated facilities with limited access by visitors or health professionals) makes appropriate provision of care difficult. There is an ethical dilemma for clinicians wishing to provide humane care for detainees within a system which may be seen to contribute to their plight. In this situation, psychiatrists have a moral obligation to oppose inhumane policies and practices and advocate on behalf of vulnerable groups. The Faculty of Child and Adolescent Psychiatry has taken a position opposing the detention of children and has called for the immediate release of children and their primary caregivers into appropriate community care.

Having been witness to the distress of families and children in immigration detention, having asked for their stories and heard them, we feel an obligation to report what we have seen and understood, in order to highlight the plight of these most vulnerable fellow human beings who seek refuge and protection in our country.

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Paper 2

Mares, S. & Jureidini, J. (2004). Psychiatric assessment of children and families in immigration detention: Clinical, administrative and ethical issues. *Australian and New Zealand Journal of Public Health*, *28*:6, pp. 16-22

I conceived the idea for this paper, which was developed and written jointly with my co-author. Research design and data collection were shared 50/50. The data was collected with and by the Child and Adolescent Mental Health (CAMHS) team members, who are acknowledged. They were not involved in writing up the study. My co-author organised ethics permission and data analysis. I took primary responsibility (70%) for drafting, editing and responding to all reviewer comments, and for all contact with the publisher. The paper is reproduced with permission.

This paper presents a consecutive case series of 10 families detained at Woomera IDC. Families were referred and assessed between February and August 2002 by members of the CAMHS team. It is therefore a clinical sample. The findings include qualitative and quantitative mental health data about detained parents and children. The strength of this study is the comprehensive, face-to-face, multidisciplinary assessment by at least two clinicians over time, compilation of data from the case series, and inclusion of information about young children. Limitations include the small sample and lack of data from structured diagnostic assessment tools. The paper was published alongside another study of 10 of 11 families held in another remote IDC. This was not a clinical sample. I contributed to this paper as final author, and the study was previously summarised in the scoping review (Steel, Momartin et al., 2004). Together these papers presented the first published quantitative data on children and families held by the Australian Government in remote immigration detention facilities.

Psychiatric assessment of children and families in immigration detention – clinical, administrative and ethical issues

Abstract

Objective: This paper reports the clinical, practical and ethical issues arising in the assessment of 10 consecutive referrals from a remote Immigration Reception and Processing Centre to a child and adolescent mental health service (CAMHS) between February and August 2002.
Method: The 16 adults and 20 children (age range 11 months to 17 years) were comprehensively assessed by allied health clinicians and child psychiatrists. All children were also assessed by the statutory child protection agency.
Results: There were very high levels of mood disturbance and post-traumatic symptoms in this population. All children had at least one parent with psychiatric illness. Of the 10 children aged 6-17 years, all (100%) fulfilled criteria for both post-traumatic stress disorder (PTSD) and major depression with suicidal ideation. Eight children (80%), including three pre-adolescents, had made significant attempts at self harm. Seven (70%) had symptoms of an anxiety disorder and half reported persistent severe somatic symptoms. The majority (80%) of preschool-age children were identified with developmental delay or emotional disturbance. Few clinically based recommendations were implemented.
Conclusions: Very high levels of psychopathology were found in child and adult asylum seekers. Much was attributable to traumatic experiences in detention and, for children, the impact of indefinite detention on their caregivers.
Implications: Multiple obstacles to adequate service provision are identified. Adequate clinical intervention and care was not possible. The impact on involved clinicians is discussed.

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In 1990, Australia ratified the United Nation's Convention on the Rights of the Child and this was scheduled into the Commonwealth Human Rights and Equal Opportunity Act in 1993. The United Nations Commissioner for Refugees (UNHCR) Revised Guidelines relating to the detention of Asylum Seekers[1] concluded that detention was undesirable, should not be prolonged and that children should *not* be detained (UN emphasis). The guidelines stress the importance of ensuring a normal home environment for children and access to school and other appropriate support systems.

Since 1992 Australia has had a policy of mandatory detention of all unauthorised arrivals, including families and children seeking asylum. Detention, often in remote or offshore centres, is indefinite while applications for refugee status are processed, or until applicants are removed from the country. This can take years. Australia's policy of detaining accompanied and at times unaccompanied children has attracted considerable domestic and international concern and criticism.[2,3]

The Department of Immigration, Multicultural and Indigenous Affairs (DIMIA) contracts the running of Immigration Detention (IDC) and Immigration and Reprocessing Centres (IRPC) to a private company, and this contract includes provision of medical care. At the time of these assessments the centres were run by Australian Correctional Management (ACM), which is a subsidiary of an American company, Wackenhut Corporation. Medical and allied health staff employed to work in the ACM Medical Centres are usually subject to contracts that prohibit speaking publicly. When detainees require specialist care or hospital treatment this is provided by privately employed medical practitioners or State Government health services who are reimbursed by DIMIA for treatment of detainees.

This paper describes the findings and experience of a child and adolescent mental health service (CAMHS) that was requested to provide specialist service to detained children and families in a remote IRPC. Referrals to the CAMHS service began after child psychiatrists undertaking assessments to support legal processes expressed significant concern about the mental health of children in this remote location. At the time of the initial assessments there were no confirmed arrangements between State Departments of Health and Community Services for provision of mental health assessment and treatment, or for responding to child protection concerns.

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Psychiatric morbidity among detained asylum seekers

In Australia, access by medical and psychiatric services to detainees in immigration detention is limited and little comprehensive information exists about the mental health of detained asylum seekers, particularly children. Those reports available indicate extremely high levels of psychiatric morbidity in populations of detained adults[4-7] in Australia and overseas.

The cumulative developmental impact on children exposed to multiple risk factors, including the mental state and well-being of their caregivers, is well documented.[8] Children in detention have prolonged exposure to multiple developmental risk factors including direct experience of personal and interpersonal violence, parental mental illness, inadequate parental protection and comfort in a context described as developmentally impoverished.[3] The impact of detention on parenting and parenting capacity has been explored in one Australian paper.[9] Children rely on their caregivers to help them make sense of the world and regulate their own responses to it. Parental mental illness increases children's vulnerability to emotional and behavioural disorders,[10] and post-traumatic symptoms in children are strongly linked to their parents' well-being and level of traumatisation.[11,12] For young children, witnessing a threat to their caregiver has been identified as the most potent predictor of PTSD.[13] In the setting of the detention centre parents have at times been the source of their child's trauma as a result of their self-destructive or otherwise disturbed behaviour.

Steel et al.[14] recently surveyed a near-complete sample of children and their caregivers in one remote detention facility. Structured diagnostic assessments were undertaken by telephone with 10 families (20 children and 14 adults). Every adult fulfilled the criteria for major depression and most had PTSD. The majority of children (having spent between 24 and 32 months in detention) fulfilled the criteria for major depressive disorder (19/20); half also had PTSD and some qualified for up to five disorders. Assessment of the lifetime prevalence of psychiatric disorders prior to arrival in Australia showed that experiences in immigration detention contributed significantly to the current high levels of psychopathology. There was a threefold increase among adults and a 10-fold increase among children in the number of psychiatric disorders subsequent to detention. Steel et al. conclude: "The rates of mental illness documented amongst the 10 families surveyed in the present study appear to be unparalleled in contemporary medical literature." One limitation associated with the cross-sectional design of this study is that while the authors employed validated diagnostic instruments, it is possible that some respondents may have exaggerated their reports of experiences and symptoms in detention. This led the then Minister for Immigration, Mr Phillip Ruddock, to reject the findings, stating that the study by Steel et al. was based on "telephone interviews without a full knowledge of any pre-existing health conditions, or any interventions undertaken by the department and the specialists involved in treating the children".[15] The present study addresses the potential limitations of this previous research by reporting the findings from a consecutive series of families referred to the CAMHS. Information obtained in a series of detailed clinical interviews, undertaken by a range of experienced mental health clinicians over time, was used to develop consensus diagnoses on each individual child and adult assessed. This methodology is consistent with Spitzer's descriptions of the LEAD approach,[16] widely regarded as the contemporary gold standard of psychiatric diagnosis.

The setting

The IRPC was situated in a remote location outside a small township several hundred kilometres from the State capital.

Method

This paper reports the assessment process and clinical outcomes for 10 consecutive referrals from this remote detention centre to a CAMHS between February and August 2002. These 10 families from Iran, Iraq, Afghanistan and Palestine included 16 adults and 20 children aged from 11 months to 17 years, and represented approximately half of the children and families in the IRPC at that time. One of the children had been born in detention, and another has been born subsequently. There were two sole parent families and one unaccompanied minor in the group assessed. All families had arrived by boat in northern Australia after fleeing their country of origin and boarding boats in Indonesia, sometimes after a protracted wait for refugee determination through the UNHCR. At the time of assessment all the families had been in detention between 16 and 20 months and had experienced at least one refusal of a visa application.

Referrals were initiated by a primary care physician contracted by ACM to provide services to the IRPC and a psychologist employed by ACM who was in the IRPC on a six-week contract. Once this psychologist left, referrals ceased, and some referrals made by her, but not yet acted on by CAMHS, were withdrawn. The stated reasons for referral varied with the age and situation of the children and families. Most involved requests for assessment

Table 1: Population sample.

Remote centre study – population sample	
	Referred clinical population
10 families	3 language groups 3 religious groups
16 adults	Age range 19-60 years (av. 35.5 years) 7 men 9 women
20 children	14 boys, 6 girls, aged 11 months to 17 years
Family structure	7 two parent, two sole parent, unaccompanied minor
Average time in detention at initial contact	1 year 3 months at initial contact (range 12 to 18 months)
Method	Comprehensive clinical assessment, multiple interviews
Conducted	February to August 2002 Followed to September 2003

as a result of threatened or actual self harm by the child, concerns about the children's well-being because of parental mental illness or self harm and/or notification of the child(ren) to child protection services in response to alleged parental neglect or abuse in the context of parental mental illness. The CAMHS staff were not privy to decision making by the referring practitioners about what constituted grounds for referral. Following referral, the CAMHS immediately allocated a team member to assess each family referred from the IRPC. Clinicians encountered substantial difficulties obtaining access to referred families with assessments repeatedly cancelled by the detention provider on the grounds that they could not provide transport or they had concerns about centre security.

All initial assessments required interpreters and took place either within the medical centre at the IRPC or at local hospital or city-based services. Assessment took on average 20 hours per family and followed the service's clinical guidelines for the assessment of children and families. All but one family (assessed by another senior child psychiatrist) were seen at least once by one of the authors. Four of the parents also had emergency assessments by psychiatrists working with adult services and required psychiatric admission to the local hospital or city-based adult psychiatric services. All preschool-age children received an initial developmental assessment by a child development team from a tertiary children's hospital.

Each family was discussed at regular telephone link-ups involving senior mental health and child protection clinicians. Management plans were developed at these meetings. Follow-up was provided in all cases, usually fortnightly or monthly. Assessment was usually protracted with frequent delays and cancellations as detailed above. All assessment included questions intended to determine the source of troubling or intrusive memories associated with PTSD symptoms. This included questions about traumatic experiences prior to arrival in Australia. Clinical recommendations were not implemented, new crises arose and children and their parents deteriorated as time passed.

All children were also assessed by the state child protection agency, often many times, on the grounds that they were subject to significant abuse or neglect. In every case, that agency confirmed that abuse had occurred. During the period reported none of the children were removed from the centre in response to these child protection notifications and assessments.

Results

Adults

All children had at least one parent affected by psychiatric illness. Only two parents gave a history of depression or other psychiatric illness prior to arrival in Australia, but only two of the 16 adults did not meet criteria for a psychiatric illness at the time of our assessment, and in five of the seven dual-parent families both parents had psychiatric illness. In both sole-parent families, the mother had required several hospitalisations for psychiatric treatment. Fourteen of the 16 adults (87%) fulfilled criteria for major depression, nine of 16 (56%) met criteria for PTSD and four had psychotic illness requiring hospitalisation. Five (31%) had made significant, often multiple attempts at deliberate self harm.

Children under five years old

Of the 10 children five years and under, seven had spent at least half their lives in immigration detention. Five (50%) presented with delays in language and social development and/or emotional and behavioural dysregulation. Their parents reported that the children had disturbed sleep and feeding routines and complained that they "didn't know how to play", and no longer obeyed them. Three of the infants (30%) showed marked disturbance in their behaviour and interaction with their parent or carer, indicating disturbances or distortion of attachment relationships. All of these children had been exposed to violence and chronic parental mental illness. Over the 12-month follow-up, oppositional behaviour and parent-child relationship difficulties were identified in a further three children, indicating that 8/10 preschool children had displayed some form of developmental or emotional disturbance.

Example 1:

In the richer environment in which assessment occurred, 'A' aged 3 moved busily from one activity to another, eagerly seeking to use toys in a way that suggested he had never before seen a puzzle, or scissors, and that he was uncertain what to do with a picture book. His mother initially smiled and then wept as she watched his pleasure at exploring the toys and the room.

Example 2:

'M' aged 3 sat in the corner eating bits of foam rubber and paper rather than exploring the toys. He repeatedly ran out of the room despite being told not to. His behaviour was restless and disruptive. When seen with other children he was aggressive without provocation, hitting, biting, spitting and swearing in English although all his other words were Arabic.

Example 3:

When seen with her mother, 'L', an 18 month old, was unhappy and unsettled and made little eye contact with mother or the interviewer. She demonstrated persistent fussing and whining, and when offered food, drink or toys, threw these away. She was unable to settle enough to explore toys. Although appearing to seek comfort from her mother, she struggled when picked up. This child had been notified to child protection services after her parents had placed sticky tape over her mouth in an attempt to keep her quiet after conflict with other detainees in the shared accommodation who were complaining about the toddler's constant crying.

Children aged 6-17 years

Of the 10 children aged 6-17 years old, all (100%) fulfilled criteria for post-traumatic stress disorder (PTSD). All were troubled by

Table 2: Results, adult psychopathology.

Diagnosis	Sample 16 adults age range 19-60 years	
Major depression	14/16	87%
PTSD	9/16	56%
Psychosis	4/16	25%
Other factors		
Self harm	5/16	31%
Psychiatric admission	4/16	25%

experiences since detention in Australia. Only one also reported troubling thoughts about events on the boat to Australia, although all were asked about this. All had witnessed attempted hangings, slashings and self-poisoning and each reported graphic intrusive memories and thoughts of adults self-harming. For some this included memories and images of their parents during and after self harm. One child had witnessed her mother cut herself and write on the wall in her blood. Another had seen his parent attempting to set fire to herself during a psychotic episode. All 10 reported anxiety about their parents' well-being.

Example 4:

'M', 'aged 12, drank coffee in an attempt to remain awake all night for fear that his depressed mother or psychotic father (whom he had witnessed dancing naked in the camp) might come to grief without his vigilance. He had been victimised by other detainees and guards because of his father's bizarre and provocative behaviour.

Within the IRPC there were times when self-destructive behaviour had escalated to daily cuttings, hanging attempts and provocation of conflict with ACM staff by children, adolescents and adults. Several children expressed a fear of harming themselves "because everyone does it here".

All reported trouble sleeping, poor concentration, little motivation for reading or study, a sense of futility and hopelessness and overwhelming boredom. All children were troubled by recurrent thoughts of death and dying. All children in this age group (100%) fulfilled the criteria for major depression with suicidal ideation. Some were angry, but for others this had given way to despair. Withdrawal and emotional numbing were prevalent. One 13-year-old said, "my heart has become hard". Nightmares were very common, and three (30%) of the younger children reported frequent nocturnal enuresis since being in the IRPC.

All reported recurrent thoughts of self harm. Three pre-adolescent children (aged 7, 10 and 11 years) were among the eight (80%) children who had acted on these impulses, some self-cutting, but others making potentially lethal attempts, by hanging. This is different from patterns seen in community samples where deliberate self harm is rare in pre-adolescent children.[17,18]

Seven (70%) also had symptoms of an anxiety disorder (panic disorder, generalised anxiety disorder, separation anxiety). Half (50%) reported persistent severe somatic symptoms, particularly headaches and abdominal pain.

All children reported extreme boredom, anxiety about falling behind in their schoolwork and shame about knowing less than age-appropriate peers. A common preoccupation among the children was the apparent randomness of the refugee determination process. Children could not understand why other families that they had met in the IRPC had now been granted visas and they had not. The sense of injustice arising from this was in turn associated with extreme feelings of anger and self worthlessness. One girl said: "What kind of bad person am I that this has happened to me?"

Parents frequently reported that they had in part left their country of origin out of fears that their children were at risk of violence or persecution for religious or political reasons or had limited access to education and other resources. All expressed considerable guilt and despair about bringing their children into a traumatising and hopeless situation. Some expressed a wish to die in the belief their children might fare better without them.

Example 5:

'S' (mother) said 'Leave me in the camp to die, but please get my children out of there'.

'P' attempted to have her son adopted by another family, believing he was better off without her.

'Z' was reported by her daughter to have said, 'you don't have a mother any more. Go on with your life and be a good girl.'

Many of the children had assumed adult roles and responsibilities, surrendered by their parents because of their own ill-health.

Example 6:

'S', an 11-year-old girl, was doing most of the parenting for her five siblings under six. Both parents were depressed and overwhelmed.

'R', an 11-year-old boy, was left to care for his younger brother during many weeks that their mother was in hospital with psychotic depression.

Table 3: Diagnosis – 10 children aged 6-17 years.

ID	Age at referral	Male/ female	Major depression	PTSD	Anxiety disorder	Enuresis	Somatic symptoms	Deliberate self harm
1	17	F	*	*	*		*	
2	17	M	*	*				*
3	14	M	*	*				*
4	13	F	*	*	*		*	*
5	13	M	*	*	*	*	*	*
6	12	M	*	*			*	*
7	12	F	*	*	*			
8	11	F	*	*	*	*	*	*
9	10	F	*	*	*			*
10	7	M	*	*	*	*		*
Totals	**10**		**10**	**10**	**7**	**3**	**5**	**8**
			100%	**100%**	**70%**	**30%**	**50%**	**80%**

There is incomplete information about the extent of prescribing of psychotropic medication to these families during this period. Information about medical treatment provided by ACM medical staff, the primary care physician or adult psychiatric or other visiting services was frequently not available to CAMHS staff despite verbal and written requests. The lack of comprehensive information about prescribing of psychotropics and compliance by detainees with such prescription has clear health and welfare implications for the population and service implications for staff.

Recommendations and their implementation

In each case, comprehensive mental health assessment of children and parents resulted in recommendations that adequate treatment was not possible while they remained in the IRPC environment. In no case was it judged that medication or other intervention carried out while the family remained in detention could be expected to have a significant impact on morbidity (although in the majority of cases some intervention, e.g. fortnightly visits for therapy, was also recommended in the hope of lessening suffering). In no case was the primary recommendation by the CAMHS team implemented by the detention authorities.

Family circumstances 12 months after initial referral

In September 2003, 12 months after initial referral, five of the 10 families remained in detention, now for periods up to 30 months. Another child had been born, and further admission of adults for individual psychiatric treatment had occurred.

Of the five families still detained in September 2003, three remained in an IRPC and two had been relocated to a remote community housing project where the father was required to remain in the IRPC with infrequent access to the family. The well-being of all five families deteriorated during the course of the year's follow up, with members becoming increasingly agitated and suicidal as time in detention passed. Further riots and fires had occurred and although schooling opportunities for the children had improved, all children continued to have a limited range of developmentally appropriate experiences and were exposed to continuing trauma and parental illness and distress.

Two families, and an unaccompanied minor, were released on temporary protection visas (TPV) from detention centres during the six months after initial assessment and two in the month prior to writing. None of the releases were in direct response to CAMHS recommendations and in one family the mother and children were granted temporary protection visas but the father was not. The average length of time in detention for those five families who received visas was 24.8 months (range 12 to 30 months). Most family members reported an initial improved sense of well-being on release from the IRPC, either on TPV or into community housing, despite in one case separation from the father, but such improvements were short-lived in all but two cases. The lack of sustained improvement in those released on TPVs might be due to the fact that their long-term future remained unclear. There is evidence in adult populations that TPV holders in the community have higher levels of distress than those granted permanent residency, and that they may in fact suffer "anticipatory PTSD".[14]

Table 4: Family circumstances 12 months after referral, September 2003.

Sample	10 families
Remaining in IRPC	37 adults, 6 children
Community detention	22 adults, 3 children
TPV/humanitarian visa	57 adults, 12 children
Average time in detention prior to granting of visa	24.8 months (range 12 to 30)

Discussion

Comprehensive assessment of these children and their parents by experienced clinicians over time identified distressingly high levels of psychopathology similar to those identified by Steel et al.[14] in their survey. The strengths of this report lie in the direct clinical assessments and the involvement of at least two experienced clinicians with each family in order to reach a consensus diagnosis over time. The diagnostic procedure employed in this study addresses the perceived limitations of previous cross-sectional assessments, which have been alleged[15] to be unreliable, as respondents may have exaggerated their reports of experiences and symptoms in detention. A possible weakness of this study is the lack of standardised structured diagnostic assessment tools, which have been demonstrated to be more accurate in identifying multiple disorders. For example, Steel et al.[14] reported high rates of oppositional defiant disorder and separation anxiety disorder among older children. Because the major and immediate focus of concern in the current study was assessment of safety, in the context of threats of self-harm or severe parental mental illness, rather than establishing diagnosis, under-diagnosis was possible.

Another limitation of our study was the relatively small number of families assessed. There did not seem to be any system as to which families were referred; however, even if only the most disturbed families were referred for assessment, those referred constituted half of the total population of detained families in this facility, so that rates of psychiatric illness would still be remarkably high.

Compromised clinical standards

Mental health services available to families in immigration detention are significantly compromised, not only because of limited access to clinicians but because recommendations aimed at improving detainees' psychological and social circumstances cannot be implemented. In child and family psychiatry, assessment is centred around consideration of the impact of systemic and family factors on well-being and development, rather than simply a focus on individual diagnosis. Similarly, intervention in child psychiatry is likely to address family and broader systemic issues, aimed at facilitating normal development and preventing psychopathology. Adult psychiatric services generally focus on the diagnosis of a psychiatric illness in an individual, to whom

intervention is then offered. In practice, particularly in acute situations, the biological aspects of intervention may take priority (although they would rarely be the sole intervention). It has been argued that in the absence of a clear diagnosis, or diagnosis of an adjustment disorder related to the detention context, the psychiatrist has little to offer the detainee in the IRPC. Particularly in the case of families in immigration detention a narrow, 'biological' approach significantly devalues the environmental and systemic context of psychopathology that is overwhelming in the detention context. Unfortunately, perhaps because of an inadequate understanding of this systemic context, we observed cases in which adult services underestimated or ignored the impact of parental mental illness or hospitalisation on the detainees' children, and children were left effectively unattended or in ad hoc care in the IRPC.

It was not the role or intention of the CAMHS staff to use assessment as a platform for political debate. However, once CAMHS staff had become involved in these cases it was not possible to set aside the significant and ongoing developmental impact of the impoverished and traumatising detention environment and continuing parental mental illness. Therefore, recommendations about the mental health of children, all of which were based on clinical assessment, necessarily included statements about the needs of their parents and the need for removal of families from detention. These assessments and reports were not acted upon, despite the extent of the psychopathology identified. This experience called into question the clinician's role in attempting to provide a service in this environment. The difficult moral and ethical issues posed to psychiatry as a profession by this aspect of federal policy has been discussed by Silove.[21]

The question of whether it is possible to be therapeutic in this context remains moot. For some families, ongoing support included a trip out of the IRPC and for separated families, a chance to see their father or husband. Families reported the benefits of these visits as primarily breaking the monotony of camp life, but resulting in no substantial change. Clinical staff found themselves bearing witness to families whose mental health and overall functioning deteriorated as their time in detention extended. This pervasive deterioration also raises serious concern and is at odds with international research demonstrating improvement over time among refugees and post-conflict populations.[19,20]

State/Commonwealth issues

State and Commonwealth tensions are brought into focus by health and child protection concerns about these children, all of whom were known to State child protection services. Given that the Federal Minister "as a matter of policy is not prepared to release the whole family into the community" (p 22.14), Layton[22] notes the *"State has no jurisdiction to require the release of a child's family from the detention centres in order to ensure the best interests of the child"* (p 22.12). This release can only be achieved with the co-operation of the Federal Minister. Thus as Justice Bhagawati, chairman of the United Nations Human Rights Committee, notes:[3] *"the Minister for Immigration is both the 'detainer' and the guardian, which represents a serious conflict of interest" (*quoted in Layton, p 22.10).

Layton notes "*the [Memorandum of Understanding between State and Federal Governments] does not recognise the serious systemic abuse of children in detention and that the most serious abuse does not come from individuals, but arises from the circumstances of detention itself"* (p 22.14). At the time of writing a number of legal attempts to test and explore jurisdictional areas of responsibility and power in relation to care and protection of these children are under way.

Impact on involved clinicians

The CAMHS and staff undertook this work with the same commitment to early intervention and prevention, an emphasis on optimising developmental potential, and understanding children's difficulties in the context of their family and social environment as is demonstrated in response to all appropriate referrals to the service. Staff involved in these attempts at service provision were responsible for, but felt unable to assist, children and parents with severe psychiatric illness and distress. Extensive time was spent in negotiating the numerous administrative and practical obstacles encountered in responding to referrals. There was potential for significant vicarious traumatisation of workers. Out of sight has not been out of mind, and involved clinicians report carrying with them feelings of impotence, anger, hopelessness, avoidance, numbing, sadness and despair, feelings resonating with those experienced by detainees.

Over and above their statelessness and their cultural and religious isolation, adults and children in immigration detention are alienated by their official status as 'unauthorised non-citizens'. The clinician encounters a system within which not only those they advocate for, but they themselves have little power. Because Australian immigration law takes precedence over State health and child protection jurisdictions, the clinician is unable to effect significant change. Some clinicians felt that their expertise had been denigrated; others felt impotence and guilt that so little was achieved to protect patients from the effects of ongoing incarceration that occurs in our name, apparently with majority public support.

To maintain staff moral and to share the clinical and emotional burden of the work, a number of strategies were put in place. These included allocating assessment and follow-up of families across a number of country area teams and limiting the number of families from the IRPC carried by any one clinician. Visits to the IRPC to conduct assessment and follow-up were undertaken jointly by groups of CAMHS staff, and weekly telephone conferences between involved staff members and a nominated child protection worker were used to update on progress and arrangements for subsequent assessments and visits. Staff debriefing occurred following particularly difficult events.

Conclusions

Comprehensive assessment of 10 families referred to CAMHS from a remote IRPC identified a population with very high levels of psychopathology and distress, comparable with the research sample described by Steel et al.[14] although methods of sampling

Author: Please place references to tables in text, e.g. (see Table 1), etc

and assessment differ. Treatment planning and intervention were substantially unsuccessful for complex political and administrative reasons. Staff had no power to implement therapeutic recommendations, yet were responsible for providing a service to these families who they saw deteriorate over time.

Public health implications

The authors believe, in accordance with statements made by other professional bodies,[23] that health professionals have an ethical duty to care for patients regardless of citizenship or visa status and that all people have a right to adequate health and mental health services, regardless of their citizenship or visa status. These principles are significantly compromised in the context of Australia's present immigration policy.

There are multiple obstacles to adequate mental health service provision to families in immigration detention. These arise because of their indeterminate immigration status, physical, social and cultural isolation, and the politicised climate within which their ongoing detention occurs. Splits in responsibility for service provision and decision making about their well-being and future also contribute and occur at the level of State and federal government, adult and child psychiatric services, health and child protection services and public and private organisations. These factors have a significant impact on involved clinicians and raise questions about their role in this context.

Is it appropriate to continue to offer assessment and attempt interventions (supportive or otherwise) in a context where clinical standards are compromised, clinically based recommendations have not been implemented, the detention context is identified as a major source of the distress, and service provision can be misused to argue that detainees are receiving adequate specialist mental health care? What responsibility do clinicians as individuals and as service providers have to these parents and children in need and at what point is advocacy at a social and political level justified, if not inevitable?

These questions persist while mandatory indefinite detention of all unauthorised arrivals remains a central plank of Australian immigration policy and law. The infants, children and adults described live on our soil but outside the structures that protect citizens from dehumanising indefinite incarceration, ongoing traumatisation and, particularly for children, exposure to violence in a developmentally impoverished environment.

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Ethical approval to publish this material has been obtained from the relevant institutional Patient Care Ethics Committee (contact person, Dr Paul Henning, 08 8161 7303).

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Papers 3 and 4

Mares, S. & Zwi, K. (2015). Sadness and fear: The experiences of children and families in remote Australian immigration detention. *Journal of Paediatrics and Child Health, 51*(7), pp. 663-69

Zwi, K. & Mares, S. (2015). Stories from unaccompanied children in immigration detention: A composite account. *Journal of Paediatrics and Child Health*, *51*(7), pp. 658-62

These two papers were published in the same edition of the *Journal of Paediatrics and Child Health* after a seven-day visit to detention facilities on Christmas Island in March 2014, and a subsequent three-day visit to facilities in Darwin. My paediatric colleague Karen Zwi and I were medical consultants to the 2014 AHRC inquiry. Both papers were conceived, written and submitted jointly, with a 50/50 share of the responsibilities for design, data collection, writing and editing. The papers are reproduced with permission.

The papers resemble the 'intensive case study' and modified participant/observer accounts described above in the initial Woomera paper (Mares et al., 2002). The unique opportunity to visit detained children and families in the consultant role enabled extended contact over seven days of visits to families and children held in various facilities on remote Christmas Island. During the AHRC meetings we provided paper and pencils and invited children to draw pictures to tell us about their lives. We also had contact with a wide range of detention and health service staff.

Paper 3 provides a description and analysis of the circumstances for detained families. Paper 4 is focused on the experience of unaccompanied children held in a separate facility on Christmas Island. The children's experiences are included as directly as possible through their words and drawings, alongside de-identified vignettes and parents' words. Based on this information, conclusions about the impact of immigration detention on children and families are made.

These visits provided a broader perspective from that obtainable as a psychiatrist visiting particular families for the purpose of medicolegal assessments. In addition to material recorded while during the inquiry visits, I made personal notes each evening, recording additional observations. I provided summary reports for the AHRC and the Royal Australian

and New Zealand College of Psychiatrists (RANZCP)bout the visits, and gave oral evidence at a public AHRC hearing (Mares, 2014). Writing the papers with Karen Zwi provided further opportunities for reflection and documentation.

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VIEWPOINT

Sadness and fear: The experiences of children and families in remote Australian immigration detention

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Background

In March 2014 we spent a week on Christmas Island as consultants to the Australian Human Rights Commission (AHRC) Inquiry into the Impact of Immigration Detention on Children. We were accompanied by three AHRC staff. We had extensive access to detained families and children and conducted semi-structured and informal interviews with 230 people as individuals or in family or other groups. We met with staff of the Department of Immigration and Border Protection (DIBP) and 'service providers' including Serco, the multinational corporation that runs the detention facilities, International Health and Medical Service (IHMS) and the non-governmental organisation providing activities for unaccompanied children (Maximus). DIBP staff were present at all meetings except those with detainees. We used official interpreters for the majority of interviews but occasionally used other asylum seekers, including children to translate. The AHRC provided two debriefing sessions following our return. A report, 'The Forgotten Children: National Inquiry into Children in Immigration Detention' was released by the AHRC to the Australian Government in November 2014, with public release in March 2015. In a separate paper, we focus on the unaccompanied children and young people detained in Immigration facilities on Christmas Island.[1]

Policy context

Australia is a signatory to the UN Refugee Convention (1951) and in December 1990 ratified the Convention on the Rights of the Child (CRC). The UN CRC identifies that children need Provision (of food, shelter, education); Protection (from harmful and traumatic experiences, including abuse, torture, exploitation, arbitrary detention) and the chance to Participate in decision-making about their lives. These rights are largely enacted in policies for Australian children even though the CRC has not been incorporated into Australian law.

The current policy of mandatory indefinite detention is the legal requirement to detain all non-citizens arriving in Australia without a valid visa. First introduced in 1992, it has been extended by successive Governments, which have also altered the migration zone and introduced offshore processing. Under current immigration law, Australia therefore detains all asylum seekers (children and adults) arriving without appropriate documentation. In recent times, the intention to use harsh measures as a deterrent to potential asylum seekers has become explicit.

In September 2012, the Government re-instated third country processing for asylum seekers who arrive by boat and then announced a Regional Settlement Arrangement (RSA) under which asylum seekers arriving by boat after 19 July 2013 would be transferred to Nauru or Manus Island (Papua New Guinea) for processing. No asylum seekers arriving 'unauthorised' by boat would have their claims processed or be re-settled in Australia. It has been argued that many of Australia's current policies and practices infringe the human rights of those detained as well as breaching our obligations under international law.[2,3]

The families and children

The families and children we met on Christmas Island had arrived after the RSA was announced on 19th of July 2013. They had been in detention for 6–9 months, and no processing of their asylum claims had occurred. They were predominantly from Afghanistan, Somalia, Sri Lanka, Burma, Syria, Iraq and Iran.

At the time of our visit there were 1700 detainees on Christmas Island, of whom 356 (21%) were children. Twenty-five infants had been born in detention, and 20 women were currently pregnant. Half of the children (171) were aged 5 years or under, and there were 41 unaccompanied children, those under 18 years old without family to care for them. Although we met with detainees in their language groups, we provided materials and invited children to draw pictures to tell us about their lives. It has long been recognised that children use drawings and play as ways to communicate and process their experiences.[4,5] The nature and content of their drawings is understood to be influenced both by factors intrinsic to the child, including their developmental level, and by external factors, including the context and the family environment.[6]

Evidence about the impact of immigration detention

Considerable research in Australia and overseas in the last decade has confirmed that detention is harmful for adults and children, with worse impacts the longer the detention continues. There are high rates of mental illness and self-harm in

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detained populations and suicide rates 40 times the Australian average in detention centres in Australia.[7–9] There is no published research on the specific impact of offshore detention and recent policy changes, but the harms are likely to be even greater given the isolated and harsh circumstances, increased uncertainty about their future and logistic difficulties with adequate service provision.

The impact of childhood adversity

There is mounting evidence that adversity during pregnancy and early childhood including exposure to violence, trauma and parental despair can disrupt normal development, adversely affecting children's lifetime health and well-being. Evidence from large-scale longitudinal studies suggests that early exposure to chronic stress and adversity accounts for a substantial proportion of the risks for a range of child and adult outcomes including mental illness and chronic disorders associated with premature mortality.[10] The gravest impacts come from cumulative and prolonged adversity, particularly when these are not mitigated by protective experiences. Positive learning environments such as quality childcare, school and meaningful activities with supportive adults are protective for children facing adversity,[11] including refugee children.[12]

Detention on Christmas Island

Christmas Island is a small, very remote island in the Indian Ocean, with a culturally diverse local community of fewer than 2000 people. Community life is heavily affected by the detention facilities and the influx of uniformed staff associated with Australia's immigration processes.

The detention facilities where families were housed resembled prisons, although they were designated as 'Alternative Places of Detention' (APODs). High double-electric and barbed wire fences, security gates and cameras surrounded the compounds. Although we were informed by an officer that 'the fences are not turned on', the visual impact was intimidating.

Families lived in 'dongas' (recycled shipping containers), most with communal toilet and shower cubicles. Waste water was running out freely from at least two of the ablution blocks near walkways and play areas. Many people told us that the facilities had been filthy until a few days before our visit. Each family occupied a small room in a 'donga' with single bunk beds, fold-away mattresses and no private eating or recreation area. Detainees were served meals in large dining halls, and there were few shaded communal areas where they could gather and no shaded places designated for children's play. There were very few toys or books that parents could read to their children. Parents complained that they could not put their infants down to crawl or walk as the ground was stony and they feared injury.

Daily life in the camps

We observed little opportunity for meaningful or satisfying activity, with very limited schooling for children and no adult work, skills training or education apart from English lessons (Fig. 1). Most children had been to school for only a few hours on a few days of the months detained. Adults complained of extreme boredom and monotony, with each day much the same as the last. There are daily frustrations including lining up for meals and medications and the 11pm and 5–6am head counts when an officer enters the bedroom and requests ID numbers (Fig. 2). This adds to the already disturbed sleep of many families.

Almost all adults and children handed us their ID card before responding to our request for their names. The ID card has a prominent number signifying their boat arrival number and an individual ID. Children regularly placed their numbers not their names on their drawings. Various lists were displayed around

Fig. 1 'Sad people lining up and waiting in the rain'.

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Fig. 2 An 11-year-old's story: (right to left) war at home; fear on the boat; sadness in detention.

Fig. 3 A 5-year-old draws their family.

the camp, with numbers used as identification. One detainee said: 'It's as if our number is our first name . . . see the number is much bigger (on the card)'.

Children's health, development and well-being

Children were crying, anxious or withdrawn while we spoke with families (Figs 2,3). They reportedly have disturbed behaviour and sleep, some with recent enuresis or other developmental regression. Several were biting themselves, hitting their heads in distress or aggressive to others. Parents were deeply concerned about delays in their children's speech, limited opportunities for education and safe exploration, and recurrent games about drowning at sea or pretending to be 'officers'. Teenagers described feelings of hopelessness and injustice.

We saw children with impetigo and other infections, readily treatable with antibiotics and regular hand washing, but

adequate soap is not always available, children are not proactively screened and these highly infectious conditions spread rapidly in the crowded tropical environment. Several children had rotten teeth and parents reported night waking with toothache. Most had not seen a dentist during the many months of detention.

We received contradictory information about developmental assessments. The health service did not appear to complete any regular or standardised assessments or keep growth charts. We were subsequently told that regular height and weight checks were done on infants, and there was a 'project' to set up a 12-month developmental assessment that had not commenced. Several families complained that for months children's broken glasses had not been replaced and that children with severe hearing impairment had been inadequately assessed.

Medical staff maintain a 'Children of Concern Register', which includes children with growth faltering, unexplained fever or recurrent illnesses. These children receive more frequent monitoring, but staff told us that sometimes treatment recommendations including mainland or community transfer are not supported by DIBP. Public statements by doctors employed in detention health services have raised concerns regarding the quality of services provided in remote detention camps. The professional and ethical issues facing health professionals working in these facilities have been explored elsewhere.[13–15]

Parenting

We were told by a Serco officer: '*Interactions with families are based around the autonomy of the parents. Parents have the same opportunities as those in the community (to care for their children)*'. However, family life, parenting capacity and parental discipline are severely undermined by the physical and psychological environment of detention. Parents expressed their deep commitment to their children and their wish for a better future, yet feel thwarted, describing themselves as unable to function adequately due to uncertainty about their futures and fear of anticipated transfer to Manus or Nauru. Pregnant women and mothers complained about being unable to cook or assist in preparing meals and a lack of fresh fruit and vegetables, showing us packaged fruit with expired 'use by' dates.

Parents described as humiliating the repeated lining up at meal-times in sun or rain to show their ID cards, carrying the standard issue plastic cup, plate and cutlery (Fig. 2). Those with illnesses queue again several times each day for medicine to be dispensed or to see the nurse or doctor. For those with infants there is additional lining up for nappies, baby wipes and scoops of formula, with limited amounts dispensed each time.

> *There is not enough child-care or crèche; baby food is a problem too. No potties, lack of prams and cots. Also children are 'parentified', saying things like: 'Mummy did you have breakfast?'* (Nurse)

The psychological environment

Single father with children aged 4 and 6 years

The boys were very disruptive and their father did not intervene, saying in front of them, '*I cannot look after my babies. I wish I was dead but what will happen to my babies? Will someone take them from me? I cannot look after them*'.

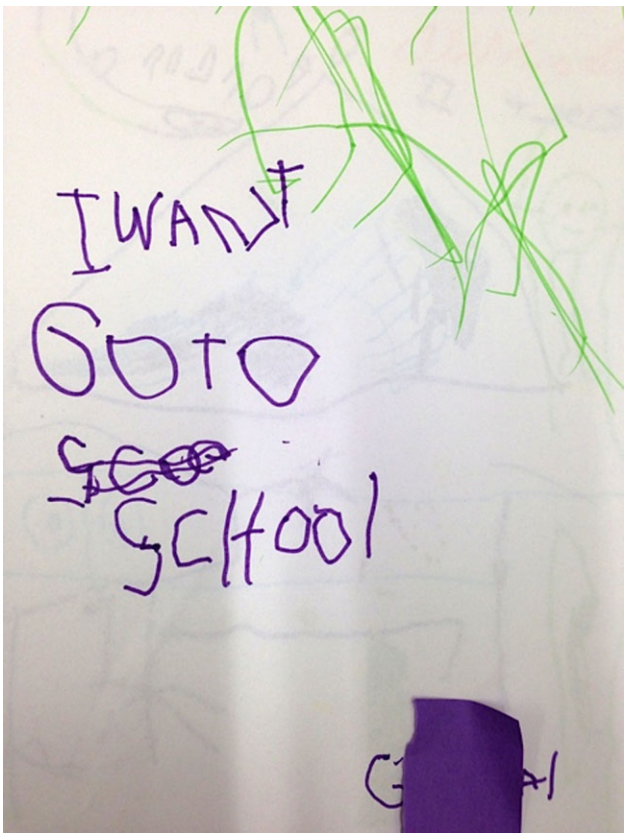

Fig. 4 A child's plea.

There are clearly demonstrated negative outcomes for children exposed to parental mental illness.[16,17] This has a cumulative impact in environments that are simultaneously monotonous but also unpredictable and potentially traumatic. Depression, anxiety, despair and current or past trauma also affect parental responsiveness and assertiveness in seeking help. Many children had witnessed adults self-harming including cutting, drinking toxins, a hunger strike (during our visit) and lip sewing. Parents described feeling unable to protect children from distressing exposures or to comfort them adequately and help them make sense of what was happening. This adds to their own sense of guilt, despair and inadequacy as parents. Children show parental vulnerability in their drawings, which convey a strong sense of powerlessness and imprisonment (Figs 4,5).

> *When I see my parents crying I feel very sad. When I see that you are free, I want to be free as well. When they let me go. . . . to school I was happy, but sad as well. . . . I feel I am here in a zoo, like an animal behind a fence.* (10-year-old girl)

Family separations

We encountered many families who had experienced post-arrival family separation for reasons including transfer to the mainland for medical appointments or to give birth, the system of routinely moving sons to the adult male compound when

Fig. 5 A 7-year-old draws the sense of injustice: a happy family outside detention, themselves locked up.

Fig. 6 Drawing of the family by a 2 ½-year-old.

they turn 18, and relatives placed in other centres (Fig. 6). Medical transfers to the mainland sometimes caused prolonged family separations, including of children from parents. These situations were explained to us as 'operational matters' related to the complexity of remote service delivery, including space in detention facilities or seats on the plane. These separations are perceived by detainees as cruel and increase their anxiety by disrupting the few supportive relationships available. These separations were frequently identified as a source of great fear and distress.

> *The mother travelled to the mainland with the baby who was unwell. The 3 older girls (14, 11 and 8 years) were left 'in the care of Serco' in the camp for 2 weeks. The girls were without a designated adult guardian for that period and slept by themselves in their 'donga' at night.* (A single mother with four daughters)

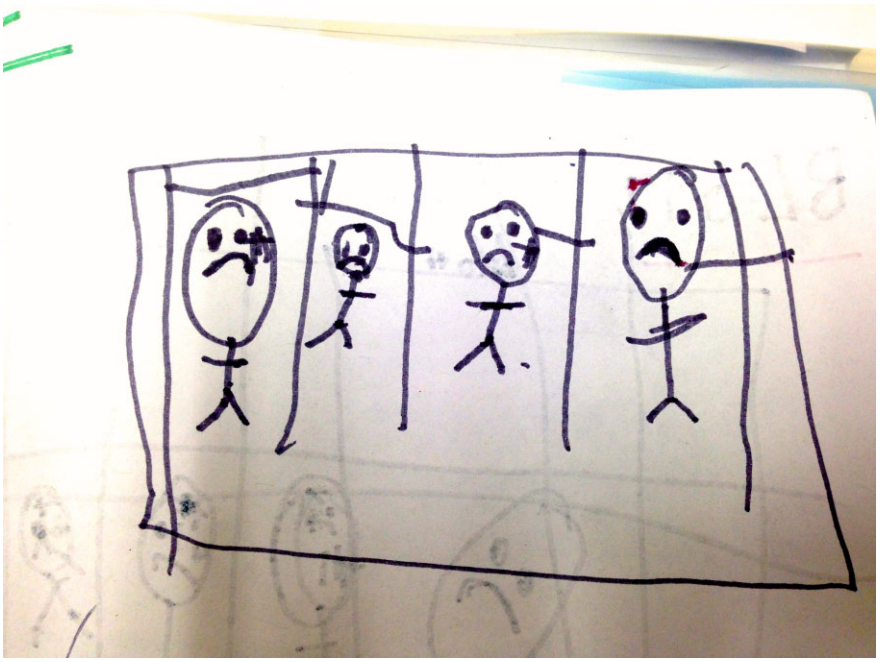

Fig. 7 A young child's drawing of their family.

My one year old daughter has epilepsy. For 3 weeks we were separated when she went to Melbourne with her mother. I would like to go too but they did not send us. We were very upset. (Father)

A pregnant woman was transferred to the mainland for investigations and there were unexpected complications. Her husband, who was mentally unwell, was unable to care for their 3 year old who became increasingly upset, losing weight and crying continuously. Despite recommendations, reunification was delayed for a month. (Story from IHMS staff who were obviously still distressed)

Particularly distressing are the separations that occur as a result of 'ageing out' (the DIBP term for turning 18 years), when boys are suddenly transferred to the adult male camp or to Manus Island. Families and unaccompanied boys live in fear of these 'extractions', which often occur in the early hours of the morning, reportedly for 'operational reasons'. Sleep disturbance and pervasive anxiety coupled with suicidal ideation is common among unaccompanied boys (Figs 7,8). This is discussed further in a separate paper.[1]

The way this is done (extractions) causes unnecessary distress. An 18 year old was suddenly moved to the adult camp. No-one let the family know; it just occurred. Distress is caused to younger siblings too by these fractures in the family unit. (Mental health staff)

Conclusions

What was most concerning about our visit to Christmas Island was the pervasive sadness and despair seen in both children and adults, their extreme fear about the future and the distress caused by daily 'operational' events that are experienced as cruel and humiliating. Most had experienced violence and bereavement in their home countries, followed by traumatic boat journeys. The children and families we met are exposed to multiple, cumulative past and current adversities. Children suffer the direct effects of the detention environment by being locked up, identified by number, exposed to violence and deprived of developmental opportunities including very limited access to education. They also experience the indirect effects of parental mental illness, family separations and inadequately addressed health conditions. Protective experiences are largely absent. It is unlikely that service providers, however well-resourced and intentioned, can mitigate the damaging impact of detention itself. Similarly, even the most committed and competent parents cannot adequately protect their children in such environments. The cumulative impact of adverse experiences in immigration detention plus prior exposures are very likely to have significant negative long-term impacts on the health and well-being of these children.

Acknowledgement

We acknowledge the contribution of the many unaccompanied children who gave us permission to share their stories and experiences, and of the AHRC in making this visit and the collection of this information possible.

Note Added in Proof

This paper, as well as two other recent publications in this journal,[18,19] were written before the release of the Australian Human Rights Commission (AHRC) report 'The Forgotten Children'. They add a personal flavour to the AHRC facts and figures and corroborate the AHRC report. The detention of families and children on Christmas Island ceased in December 2014 and the

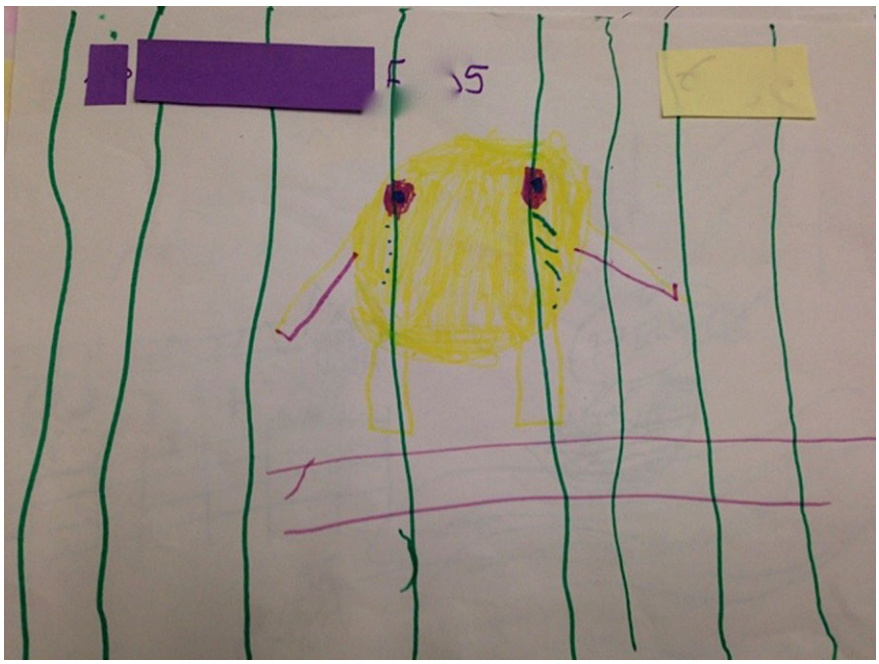

Fig. 8 This drawing is very disturbing (we do not have a record of the child's age). The crying figure lacks a mouth or nose. The bars are prominent.

facilities described were closed, but families and children remain in closed detention in Australian mainland centres and on Nauru.

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VIEWPOINT

Stories from unaccompanied children in immigration detention: A composite account

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Background

In March 2014 we spent a week on Christmas Island as medical consultants to the Australian Human Rights Commission (AHRC) Inquiry into the Impact of Immigration Detention on Children. The visit involved three Human Rights Commission staff as well as the authors, paediatrician Karen Zwi and child psychiatrist Sarah Mares, representing the Royal Australasian College of Physicians and the Royal Australian and New Zealand College of Psychiatrists respectively. Using interpreters, we spoke to over 40 unaccompanied children and service providers to ascertain processes and policies and to give feedback about detainees of immediate concern. We would like to honour the voices of the detainees; we have used their exact words where possible. In a separate paper, we focus on the families and children detained in immigration facilities on Christmas Island.[1]

Unaccompanied children are children under the age of 18 years who are seeking asylum from threatened or experienced danger. They arrive unaccompanied by a parent, legal guardian or adult relative over the age of 21 years. On arrival to Australia, unaccompanied children by law become the legal wards of the Department of Immigration and Border Protection (DIBP). The role of a legal guardian is commonly regarded internationally[2] as one who 'stands *in loco parentis* to the child',[3] which includes making decisions regarding the best interests of the child and providing for the child's emotional and material needs. In Australia, the Minister's role tends to be nominal without practical assistance offered to the children, which has been described as leaving them not only unaccompanied but also unrepresented.[4] A DIPB officer is appointed locally as the children's 'Delegated Guardian' as discussed below.

Most unaccompanied children leave their homes as a desperate measure in search of protection, education and employment, and to contribute to the welfare of their family.[5] They have often embarked on dangerous journeys, experienced war, the death of family members, persecution, violence, sexual abuse, escape from forced recruitment into armed organisations and forced domestic labour.[5] These experiences occur during critical developmental periods, thus placing them at risk of mental health problems.[5] Research is limited to a few cross-sectional or on-arrival studies, which have shown that around 25–50% have emotional and behavioural problems, anxiety, depression and post-traumatic stress disorder (PTSD), at higher rates than in accompanied asylum seeker children.[5–7] However, consistent with other studies on refugee children, the majority of unaccompanied children score below clinical cut-offs for psychiatric disorder, thus displaying a marked resilience.[5]

The severity of psychiatric symptoms is likely to increase with more traumatic events experienced prior to forced migration, demonstrating the cumulative impact on well-being of traumatic exposure.[5–8] Children exposed to adversity following migration, particularly those placed in prolonged detention, are more severely affected.[8] Studies show increased symptoms for those exposed to rioting, fires, violence and self-harm attempts by parents or others in detention. Rapid resolution of asylum claims reduces the duration of uncertainty and associated distress for children, whereas insecure asylum status is associated with a range of psychological problems that can have long-lasting effects.[8] Prompt access to services catering for physical and psychological health is important, as are long-term stability of residence and socially supportive environments.[8] It is also known that PTSD symptoms are increased in lower-support living arrangements suggesting that foster family living and high support may improve outcomes.[7]

The children and young people

We met with most of the 40 unaccompanied boys, who were aged between 14 and 17 years old, and several girls who were 17 years old on arrival and in detention on Christmas Island. We also interviewed several 18-year-olds living in adult quarters, who had been 17 years old on arrival. Most had been in detention for 6–8 months. We interviewed them with interpreters in language groups or individually. They were polite and often tearful as they spoke.

The unaccompanied children came predominantly from Afghanistan, Somalia, Iran, Burma and Sri Lanka. In most cases their extended families had pooled resources to send them away to safety. Some were orphaned, had been threatened or kidnapped, or their brothers or fathers killed. Almost all had witnessed traumatic events in their home countries such as rapes, relatives' dead and mutilated bodies or their villages burnt. The girls described the added threat of sexual assault and forced marriage to insurgent groups, which invariably also meant an end to their education. Their journeys were typically over a period of weeks to months, through India, Thailand or Malaysia, eventually boarding boats in Indonesia (Fig. 1).

These children all arrived after 19 July 2013, making them ineligible for resettlement in Australia. They were mostly in a

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"I am a young …… girl who face hardest moment in life. I was born in …… where horror was basic need in our everyday life… my parents decide to give me to someone when I was five years old. My mother, she didn't raise me up as childhood. I decided to go away and never come back…I didn't know other place to go but…I am fighting for my dreams. I think: 'I have to do something about this life'. I knew my education is the key of our lives but bad luck …. was there to stop the girls from learning. …. were there to disturb me and force my marriage. I refused and ran away to…. I advise myself no one is too old to learn. If I missed the chance to learn I didn't want my siblings to suffer the same. I was still thinking I would be able to help my family then in early 2013…..I talk to my father and I told him I want to go somewhere I can be safe and help them….then we agreed and I leave my homeland and my loved ones to help them and to have a better life…"

Fig. 1 This was written by an unaccompanied child who was 17 years old on arrival and had been in detention for close to 8 months. Nationality and other details have been redacted to protect identity.

"Detention isn't good for all children and adult – especially unaccompanied minors like me with no parents. I feel so sad without them. I leave them in horrible country and every time I'm so worried about them. Though I'm safe - I'm more stress than before because my family are in danger. And I don't have even a little hope… and I don't know where is my future?"

Fig. 2 Unaccompanied 17-year-old child detained on Christmas Island for 8 months.

camp reserved for 'unaccompanied minors/UAMs', (the DIBP term for unaccompanied children). Although designated an Alternative Place of Detention, the camp is surrounded by barbed wire fences, security gates and cameras, resembling a prison.

Guardianship

When asked about guardianship, only one boy correctly identified the Minster for Immigration and Border Protection as his legal guardian.[4] All the others nominated staff from Maximus, a non-government organisation contracted by DIBP to provide activities for unaccompanied children and to act as Independent Observers at age determination and other interviews. The children asked us: 'Who can I speak to?'; 'Who looks after me?'.

The Minister delegates his responsibility as legal guardian to the Director of Detention Operations on the Island, a busy job responsible among other things for managing accommodation and transfers of detainees. The 'Delegated Guardian' (DG) acknowledged the 'dual role' but denied any conflict. The DG spoke of being bound by the policy, consulting the Minister if children want to return home, providing advice regarding transfer of children offshore and dealing with routine issues such as medical consents, bullying and welfare. The DG did express concerns about a lack of education and meaningful activities and acknowledged that the children were terrified of transfer to Manus Island. The DG met the children as a group once or twice a week and would speak to them individually on request but did not see the role as one of personal support or advocacy.

Daily life in detention

The early post-arrival period was often described as a period of initial relief. They had survived a dangerous journey, 'the guns had stopped', they felt reasonably safe from physical danger and they were able to contact their families. However, after 1–3 months in detention and repeated messages from DIBP that 'you will never be resettled in Australia', they describe mounting anxiety regarding the uncertainty of where they might be sent for processing of their asylum claims and for resettlement, as well as loneliness and boredom.

Many children described their experience in detention as worse than adversity before migration, and this confirms previous reports on the impact of prolonged detention.[9,10]

Detention was described as: 'Torture. Torture. Torture'; 'Depression. Mental hardship.'; 'Prison. I hate this camp'; 'No hope'. We asked if there was anything good about being in detention. 'No nothing. All our friends are taken away to Manus and Nauru. We are waiting for big plastic bag to throw at us [to pack their things]. We are told the place is hell' (Fig. 2).

The age determination process

The arrival of unaccompanied asylum seekers under 18 years old obliges the Australian government to confer certain protections. Being 18 years or over means transfer to the adult male camp. Several weeks after arrival, some of the boys were called to individual 'age determination' interviews. This interview was described as the most frightening experience some had had to date. Two DIBP Officers, an interpreter and a 'Maximus Officer' accompanied the boy. Maximus has no advocacy role, so their capacity to act in the child's best interests is limited. The Delegated Guardian is not involved in the age determination interviews. One boy described being asked so many questions: 'I was confused, my mind felt tricked'. Most of these interviews took an hour but some as long as 3.5 h. The interviewers took a short break before calling each boy back in to sign a form that reportedly stated, 'You are under/over 18'. In the words of a 16-year-old boy: 'He (the observer) didn't do anything to help me. It was like he was watching TV'.

A 17-year-old boy detained in the adult detention centre described the interview as 'the worst thing; I will never forget'. He said the Independent Observer 'didn't say anything but was

"There is nothing to do here, only eating, sleeping, English classes".
"Even though we go to English class sometimes, I can't concentrate or remember".
"I cry all the time. I can't sleep. I cry all the time in my room. I'm afraid of what's going to happen next".
"I would rather die than go to Nauru or Manus".
"Of all the bad things that have already happened now, I feel I wish I died at sea instead of then dying slowly here."

Fig. 3 Comments from unaccompanied boys.

upset afterwards'. He was asked to sign a form which he did not understand and was immediately transferred to the adult detention centre where he had been detained for several months. He said he had been very afraid of the unfamiliar adult men there. When asked why he did not complain when his age was wrongly determined, he said, 'I had already told them I am 17 and showed them the paper'. Several children told us they had been wrongly 'age determined' to be adults and sent offshore but returned to Christmas Island when found to be under 18 years of age.

'Ageing out' and transfers

Children 'age determined' to be 17 years old were given a birth date of December 31 and thus all deemed to turn 18 years on 31 December 2013. This 'ageing out', (the DIBP term for turning 18) is associated with transfer to the adult camp or offshore, separation from friends and the end to any education. Transfer to adult detention occurs suddenly; several young men had been transferred in the early hours of New Year's Day. Maximus staff had introduced an 18th birthday party celebration, explaining that 'in Australia turning 18 years is a time of celebration'. This seemed incongruous given the implications for these boys of entering adulthood.

The children described collective fear of transfer to Manus Island or Nauru, which they associate with the February 2014 death in detention of Reza Berati, and dehumanising, protracted detention in tents. They reported hearing the 4am 'extractions' in neighbouring rooms: friends being told to pack their things before being taken for transfer offshore that day. The youngsters described this as 'cruel' as they 'couldn't say goodbye' to people who had become firm friends on their journeys or in detention. They did keep in touch through Facebook (detainees have internet access for a limited time each day). This reinforced their fears of the harsh conditions offshore.

Education and other activities

The children had very limited access to structured education even though their most consistent plea is the opportunity to go to school.

'This is our time, when we are young'.

'I wanted to be a doctor'.

The children had attended a camp classroom but only for a few hours a day. For many this had been for a total of 2 weeks in the last 8 months. School was described as 'mostly drawing, watching videos' and 'baby activities'. One said 'school in Australia is worse than in Somalia'. There are daily 90-min English classes, but some said they are 'too tired' to attend.

Most had been on one or two outings during the 8 months and had access to the Recreation Centre each week to play sport. There are phones in the camp, and they can earn 'points' with which to buy phone credit, used to maintain contact with family back home.

Mental health and well-being

Many children reported symptoms consistent with major depression, PTSD and/or generalised anxiety disorder. Many were tearful and a few appeared psychotic with confused or bizarre mood or behaviour. There was an intense shared anxiety about transfer to the adult compound or offshore and a sense of loss about peers who have been 'extracted' and transferred. Some children disclosed suicidal ideation. Signs on the fences in their compound say: 'Keep Calm and Stay Strong'; 'Keep Calm and Be Yourself' (Fig. 3).

Most children left their home countries as the selected, resourceful older child given the mission of 'saving their families', or sending money back home, but they describe themselves as 'imprisoned', 'in hell' and 'unable to do anything' for their families. Many described worries about their families at home and high levels of distress when families cannot be contacted due to the family's fleeing or relocation. News items about bombing or war in their country of origin were distressing. Several had their worst nightmares realised with the death of family members during their time in detention. Some reported pressure from families back home, not understanding their detention, saying: 'if you have money to phone, why aren't you sending us money for food?' We were told that DIBP do not routinely contact families of unaccompanied children to inform them of their children's whereabouts and processing of asylum claims.

Services and support

Mental health services are provided through International Health and Medical Services, but several children described unwillingness to talk about their experiences with the staff. Although one boy said, 'it really helps, even if you can't do something about it, just to be able to talk about it', others told of counsellors saying, 'Stop – there's nothing I can do about that' when they talked of their experiences. The young people were acutely aware that their mental health is at risk in detention and spoke of trying to 'stop ourselves from going mad' or becoming suicidal.

Previously all unaccompanied children had been automatically referred to the local torture and trauma service, which offered group and individual interventions, but this was no longer occurring.

When asked why they thought they were in detention, one responded: 'The policy changed. We are here until they decide about us.' No child had spoken to a lawyer or was aware they had a right to do so. DIBP is required to facilitate legal advice, which is done through the provision of a telephone directory and Internet access. The AHRC is of the view that all asylum seekers should be provided with the contact details of centres providing free legal services.

Many children said speaking to us was the first time anyone had listened to their stories. The current policy of offshore processing implies that no refugee processing occurs in Australia, and thus no asylum seeker is asked their reason for seeking asylum or given the opportunity to explain their arrival or have their claim processed.

None of the children expressed anger about the individual staff saying they were 'just doing their jobs' and they were quick to point out who had been kind. They took great care of each other, including acting as interpreter or support person for one another during our interviews.

When asked about her hopes for the future, one answered: 'I want to be a journalist and interview Tony Abbott (Australia's current Prime Minister) and then put him on a boat to Somalia'.

Conclusions

Detaining unaccompanied children indefinitely breaches their human rights. It compounds their prior experiences of adversity, trauma and loss of family, and their current isolation. Post-arrival detention has been shown to worsen mental health and future capacity, and the children we met confirmed this as their experience. Issues of particular concern are the lack of access to meaningful activity and education; guardianship arrangements that involve a conflict of interest; no processing of asylum claims that compounds the extreme uncertainty about their immediate and long-term futures; and a lack of opportunities to fulfil their potential. The majority of children display remarkable resilience, determination and a desire to contribute. They have not yet given up hope. If provided with protection, support and opportunities, they have the opportunity to be productive adults from whom we can learn a great deal (Fig. 4).

Born Into War

Trying to survive a home
of endless war
I witness poor people die.
They have no heart,
the cruel people
who kill the poor.
Thoughts disappear from my mind-
I don't know why they have the power to help others
but they do nothing
but make many mothers widows.
Do they realise they destroyed our homes
and many souls were gone?
I pray to God to end the pain
and the tears
in the eyes
of children
who have lost
both their parents.
As days went by without peace
we fled
like birds
we spread
across the world
like the wind.
Our names were changed
into refugees.
They used to be written in letters
but now they are numbers.
I was in darkness.
I came to a brighter place
with all my dreams.
But here I am in detention.
My future is unknown.

Fig. 4 Poem submitted to the AHRC Inquiry online site. Written by unaccompanied child on Christmas Island for 8 months.

Acknowledgement

We acknowledge the contribution of the many unaccompanied children who gave us permission to share their stories and experiences and of the AHRC in making this visit and the collection of this information possible.

This paper, as well as other recent publications in this journal,[11,12] were written before the release of the Australian Human Rights Commission (AHRC) report 'The Forgotten Children'.[13] They add a personal flavour to the AHRC facts and figures and corroborate the AHRC report. The detention of families and children on Christmas Island ceased in December 2014, and the facilities described were closed; however, families and children remain in closed detention in Australian mainland centres and on Nauru.

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Paper 5

Mares, S. (2016). The mental health of children and parents detained on Christmas Island: Secondary analysis of an Australian Human Rights Commission data set. *Health & Human Rights: An International Journal*, *18*(2), pp. 219-32

In 2015 I used freedom of information legislation to obtain unreported quantitative and qualitative data about the mental health of detained children and their parents held on Christmas Island. This data was collected during the 2014 AHRC inquiry but had not previously been analysed or published. It included qualitative and quantitative mental health data from the K10 and SDQ self-report measures. The paper also references Australian Government data on the mental health of detainees and considers the human rights implications of the findings. The paper is reproduced with permission.

The limitations of the study include the fact that gender and country of origin details were redacted before release by the AHRC, reducing the richness of data available for analysis. Ethical advice was obtained indicating that the project was consistent with the aims of the primary data collection and that the privacy and confidentiality of participants had been protected.

The Mental Health of Children and Parents Detained on Christmas Island: Secondary Analysis of an Australian Human Rights Commission Data Set

SARAH MARES

Abstract

This paper describes secondary analysis of previously unreported data collected during the 2014 Australian Human Rights Commission Inquiry into Children in Immigration Detention. The aim was to examine the mental health of asylum-seeking parents and children during prolonged immigration detention and to consider the human rights implications of the findings. The average period of detention was seven months. Data includes 166 Kessler 10 Scales (K10) and 70 Strengths and Difficulties Questionnaires (SDQ) for children aged 3-17 and parental concerns about 48 infants. Extremely high rates of mental disorder in adults and children resemble clinical populations. The K10 indicated severe co-morbid depression and anxiety in 83% of adults and 85.7% of teenagers. On the SDQ, 75.7% of children had a high probability of psychiatric disorder, with lower conduct and hyperactivity scores than clinic populations. Sixty-seven percent of parents had concerns about their infant's development. Correlations were not found between time detained or parent/child distress. Multiple human rights breaches are identified, including the right to health. This is further evidence of the profound negative consequences for adults and children of prolonged immigration detention. Methodological limitations demonstrate the practical and ethical obstacles to research with this population and the politicized implications of the findings.

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Introduction

In 2014, the Australian Human Rights Commission (AHRC) conducted an inquiry into immigration detention of children. This paper reports secondary analysis of data not analyzed or included in the inquiry report that was collected by the AHRC in March 2014 from children and families detained on Christmas Island (CI). Data included 166 Kessler 10 Scales (K10) for adults and adolescents, and 70 Strengths and Difficulties Questionnaires (SDQ) for children aged 3-17, plus responses from parents of 48 infants to questions about their wellbeing. The human rights implications are discussed.

Background

The UNHCR reports that 65.3 million people around the world are currently displaced, including 20 million already identified as refugees. More than half are children.[1] Australia is a signatory to the UN Refugee Convention (1951), and in December 1990 ratified the Convention on the Rights of the Child (CRC).[2] The CRC rights are largely enacted in policies for Australian children but not incorporated in law. Australia maintains a generous offshore refugee resettlement program, in stark contrast to the reception given to asylum seekers arriving by boat without documentation. Numbers are small in international terms: In 2013 and 2014, Australia granted positive refugee determinations for 4,949 people, which was 88% of those who had arrived by boat.[3]

Since 1992, Australia has had a policy of mandatory indefinite detention of all children and adults arriving by boat without valid documentation. This has been extended to include offshore processing and changes to the migration zone. In September 2012, the government reinstated third country processing and announced a regional settlement arrangement (RSA) under which people arriving by boat after July 19, 2013 would be transferred to Nauru or Manus Island in Papua New Guinea for processing, precluding resettlement in Australia. Between July 2013 and December 2014, while the RSA was negotiated, adults and children remained detained in Australian mainland centers and on CI, a remote island in the Indian Ocean, northwest of Australia.

Australia's policies and practices have been the subject of sustained criticism from local and international human rights and medical organizations, including the UNHCR.[4] For detained asylum seekers, the rights to work, education, human dignity, non-discrimination, equality, the prohibition against torture, privacy, and access to information, as well as the freedoms of association, assembly, and movement are all demonstrably compromised, with consequent impact on the right to health. There are identified breaches to the International Bill of Rights, the International Covenant on Civil and Political Rights (ICCPR), and the CRC, and evidence of demonstrable harm caused by indefinite detention and its consequences.[5] Recent concern has particularly focused on conditions for those held indefinitely under the RSA on Nauru and Manus Island.[6] In 2015, the UN Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment concluded in relation to the regional processing centers that "the Government of Australia...has violated the right of the asylum seekers, including children, to be free from torture or cruel, inhuman or degrading treatment, as provided by articles 1 and 16 of the CAT."[7] The AHRC has conducted two inquiries into immigration detention of children, the first in 2002 (reported in 2004), and the second in 2014. The 2004 report states that the failure "to protect and promote the mental health and development of children … not only constitutes a breach of a child's right to mental health, development and recovery, it also amounts to cruel, inhuman and degrading treatment."[8] The AHRC found Australia in breach of multiple articles of the CRC, in particular Article 3(1), which states, "the best interests of the child must be a primary consideration in all actions concerning children."[9] The 2014 report identified that "the laws, policies and practices of Labor and Coalition Governments are in serious breach of the rights guaranteed by the Convention on the Rights of the Child and the International Covenant on

Civil and Political Rights." The conclusion of this inquiry aligns with scientific studies: "Prolonged, mandatory detention of asylum seeker children causes them significant mental and physical illness and developmental delays, in breach of Australia's international obligations."[10]

The Australian government's responses to the two inquiries differed.[11] In 2004, evidence of the harms caused by immigration detention was considered new, and while the immigration minister disputed the findings, there was no sustained attack on the AHRC. Protective amendments to the Migration Act followed a change of government in 2007. The 2014 report was received with great hostility, including claims that the AHRC president had lost the government's confidence and should step aside.[12] There was a sustained political attack on the AHRC with little attempt to deny the evidence that Australia's policies cause significant harm. The Australian Border Force Act, enacted in 2015, potentially criminalized medical witnesses who spoke out about their experiences within immigration detention.[13]

Detained families and children receive health care through a government contractor, currently International Health and Medical Services (IHMS). Decisions about health needs and care provision are not transparent and there is no independent oversight or review body. Staff at IHMS and the Immigration and Border Protection system are subject to employment contracts and laws that prohibit disclosure of details surrounding detention conditions, which potentially puts them in conflict with professional standards and obligations.[14] Some doctors previously employed by IHMS have argued that health workers in immigration detention may be condoning torture.[15] In addition, given that detention itself is pathogenic, access to health care—no matter how adequate or independent—cannot sufficiently protect or treat detainees.

In mid-2014, IHMS began reporting Kessler Psychological Distress Scale (K10) mental health data from detained adults to the Australian government, and starting in mid-2015, they included Strengths and Difficulties Questionnaire (SDQ) data from children. This data was released under the Freedom of Information Act (FOI), and while it was not subject to scientific scrutiny, it clearly demonstrates clinical levels of mental health problems in detained adults and children, and shows deterioration over the period of detention. SDQ screening from 45 children shows that 82% were significantly symptomatic, scoring in the abnormal or borderline range.[16]

Scientific literature

Displaced adults and children face multiple, cumulative risks, including conflict-related exposure, trauma, and losses pre-migration, in transit, and post-arrival. Host countries support or undermine their wellbeing, with post-migration detention and insecure asylum status being particularly detrimental.[17] In 2002, this author, with other colleagues, first published descriptions of the impact of the harsh physical and psychological environment within Australian immigration detention on children and families.[18] Researchers subsequently carried out small quantitative studies demonstrating that the system was causing harm to children.[19] This added to existing research about detained adults.[20] Despite their methodological variety and limitations, international studies and review papers consistently show poor mental health among asylum seekers who have been detained, and there is evidence that even brief periods of detention—including in open centers—can impact children's functioning.[21] Rates of mental disorder are higher than in non-detained refugees with similar pre-migration risks, and length of detention is directly related to severity of symptoms.[22] Unaccompanied children, predominantly adolescents, have particular vulnerabilities due to their separation from family.[23] There is a small qualitative literature on the wellbeing of pregnant and postpartum asylum seekers, but barely any reports regarding detained infants and young children.[24] Infancy and early childhood is a period of profound dependency and rapid development, when cumulative adversity—including neglect, violence, and parental mental illness can have

long-term impacts across multiple developmental domains. Infants are over-represented in displaced populations, but a review by Fazel and colleagues identifies only 5 of 44 studies that include children under five.[25]

The study

Methods

The primary data was collected in March 2014 during the AHRC National Inquiry into Children in Immigration Detention. The author was Royal Australian and New Zealand College of Psychiatrists (RANZCP) consultant to the Inquiry and was involved in developing the methodology and collecting the data. Detailed observations made during AHRC visits to CI are reported elsewhere.[26] This study undertakes secondary analysis of data that was collected but not analyzed as part of the inquiry and was obtained under FOI in July 2015. It is therefore secondary and in the public domain. Redaction of gender and country of origin occurred before release under FOI. The project was submitted to the South Western Sydney Local Health District Human Research Ethics Committee (HREC/15/LPOOL/556), which was satisfied that the rights of participants had been protected.

Context

Christmas Island (CI) is a tiny island in the Indian Ocean covered in dense tropical forest. Small areas are cleared for phosphate mining, and there is a coastal settlement and diverse local population of about 2,000. Island life is dominated by the influx of staff and facilities associated with Australia's immigration and border protection services.

Families were held in indefinite detention on CI with the threat of transfer to Manus or Nauru or resettlement in third countries. Despite their designation as Alternative Places of Detention (APOD), the camps that housed families and unaccompanied minors resembled prisons. They were harsh and cramped, surrounded by high double fences—some of which were electrified—and guards were stationed at security gates. The ground was hard and stony, there was no grass, limited shade, and white phosphate dust covered everything. Families slept in small cabins with limited privacy, some shared bathrooms. There was little for anyone to do.

In this institutionalized setting, protective experiences for children were largely absent. Risks included exposure to parental mental illness, adult violence, and self-harm; family separations; and a developmentally impoverished environment. All adults and children were woken for head counts at 11 pm and 5 am, when they had to state their ID numbers. ID cards were required when lining up for meals or medical care. Children had few places to play safely and had received only a few weeks of schooling in the previous year.

The 2014 AHRC report identifies multiple breaches of the CRC in relation to the rights to development, health, education, and treatment with humanity and dignity.[27]

Ethical considerations

Research with detained populations is difficult and contentious, as it intersects medicine, politics, human rights, ethics, and law. In Australia, there are additional practical and political barriers.[28] These include extreme access limitations associated with the often very remote and penal nature of detention centers. Restrictions are justified on the basis of security, and prevent independent scrutiny and research on the impact of Australia's policies. If access was possible, obtaining informed consent is problematic, particularly with children, and given the extreme cultural and linguistic complexity of the population. Recent legislative changes, including the Australian Border Force Act (ABF) potentially criminalize individuals, including the author, who speak or write about the detention environment or contact with detained asylum seekers.[29]

Secondary analysis of an existing data set involves further consideration of existing data in order to answer the original research question using a different technique, or to present differing or additional interpretations. The approach has been used more with quantitative than qualitative data.[30] It raises ethical questions about consent

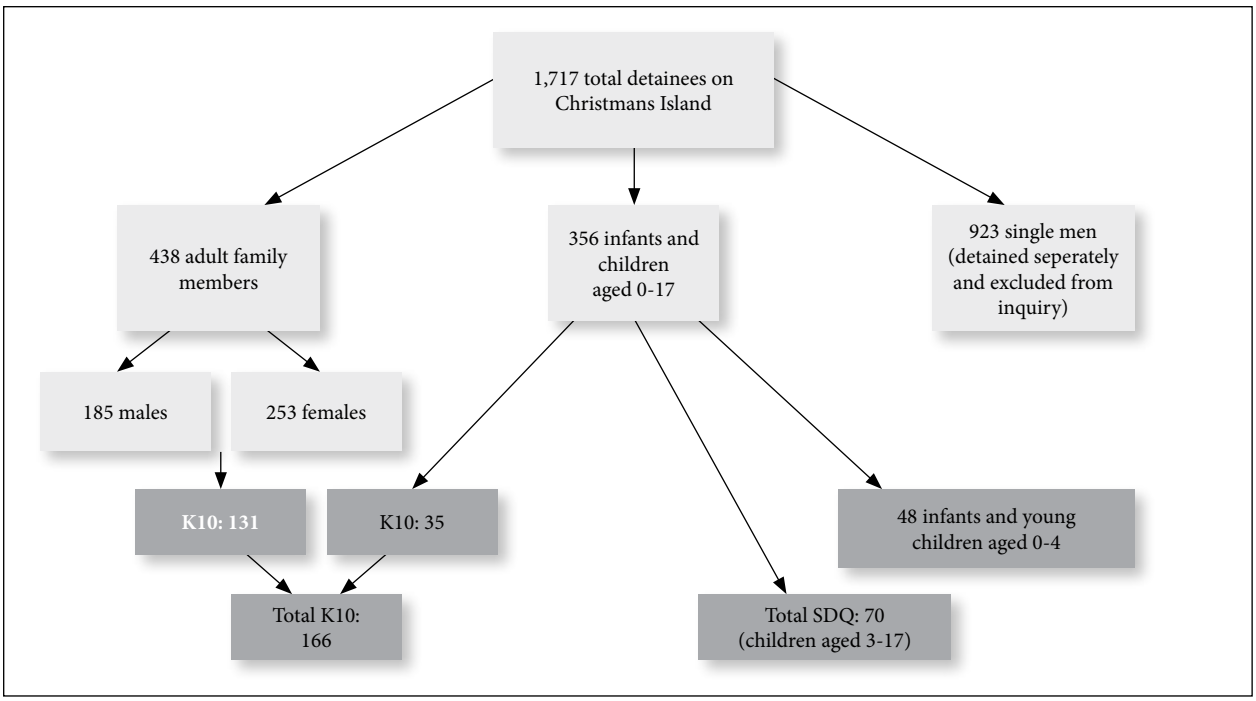
and protection of original participants.[31] Multiple steps were taken to protect participants during primary data collection and release under FOI. It was impracticable to obtain explicit consent for this study, which was not anticipated when the data was collected. It is also impossible to identify, locate, or recontact participants. Detention of children and families on CI ceased in December 2014, and all detainees have been transferred to Nauru or Manus, returned to their country of origin, or held temporarily in Australian centers or the community. This project is consistent with the aims of the primary data collection and adequately protects participants.

Primary data collection

In March 2014, children across Australia's immigration detention network had been detained for an average of eight months and were from 16 language groups, predominantly from Iran, Sri Lanka, Iraq, Afghanistan, Vietnam, Somalia, and a small number from Syria. The second largest group was Rohingya children, identified as stateless.[32] The AHRC inquiry obtained approval from the Department of Immigration and Border Protection (DIBP) to access detention centers in Australia, including CI. DIBP data shows that 1,717 detainees were held there before the AHRC visit in March 2014.[33] This included 923 single men separately detained and excluded from the inquiry. All family members and 41 unaccompanied minors (UAM, children under 18 years old without family) were invited to participate. There were 356 children aged 0-17 years held with 438 adults (185 men and 253 women). Twenty-five infants had been born into detention and 20 women were pregnant. No processing of asylum claims had occurred since July 2013.

Interviews were conducted in language groups using interpreters. The purpose of the AHRC inquiry was explained. Informal and semi-structured interviews and brief self-report questionnaires were completed. The inquiry methodology is outlined elsewhere.[34] Self-report measures included the K10 and SDQ. Only selected questions from these measures were included during visits to other detention centers and all data was collated for the report. Therefore, K10 and SDQ data from asylum seekers on CI has not been analyzed previously.

FIGURE 1: Population sample



Measures

The K10 is a self-report scale of psychological distress.[35] High distress scores indicate likelihood of a mental disorder. It has been validated in population-based and clinical populations and with a wide range of language and cultural groups, including refugee populations.[36] The SDQ is a brief behavioral screening questionnaire completed by the parent or carer, or self-reported for children aged 12-17. It is used in population and clinical studies to identify those at risk of mental illness. The 20 items are summed to create a "total difficulty" score ranging from 0-40 and 5-factor subscales (hyperactivity-inattention, emotional symptoms, peer problems, conduct problems, and prosocial behavior).[37] It has been used with migrant and refugee children, making it an appropriate measure in this population.[38]

Secondary analysis

The AHRC provided data from 365 people under FOI. This included 174 adults, 77 without children, and 97 adults in 69 family groups. The 191 children represent 48% of the 356 children then detained on CI. Time in detention, ages of children, exposure to violence, and parental concerns was provided. Gender, individual country of origin, and language group was redacted. Complete K10s were available and analyzed for 131 adults and 35 adolescents aged 12-17, 166 in total, and 70 SDQ for children aged 3-17. Parental concerns about 48 infants were collated.

Limitations

The data available for analysis has many limitations. It is not possible to determine whether this is a representative sample of the population detained on CI in March 2014; however, age and language group distribution of all children then detained in Australia was similar.[39] AHRC inquiry team members collected primary data in extremely noisy and distressing circumstances. Redaction of gender and country of origin information limits the richness of possible analysis. Levels of distress may have influenced participation. The data is incomplete in that there is only data (time in detention, SDQ and/or K10 data) for 131 adults and 105 children aged 3-17, and qualitative data on parental concerns about 48 infants. Some data was omitted or entered incorrectly during primary collection or FOI release. Five children had no age recorded, 15 are identified as UAM, yet 58 are not recorded as being part of a family and 77 of the 173 adults are not recorded as having children. This is likely to represent single women detained with the families, but may

TABLE 1: Population data

	Age	Number	K10	SDQ (ages 3-17)
Adults	18 and over	173	131	
Children	0-4	48 (25.1%)		
	5-11	104 (54.4%)		
	12-17	39 (20.4%)	35	
With parents	12-17	24/39		
Unaccompanied	12-17	15/39		
			Total K10 = 166	
Total children	Mean 7.64	191		Total SDQ =70
Family groups		69		
Time detained	Mean	Range	SD	
	209.5 days (7 months)	90-390 days	62.36 days	

The 129 children for whom data was available for secondary analysis included 48 infants and young children (37.2 %) aged 0-4, 52 (40.3%) aged 5-11, and 29 (22.5%) aged 12-17. Five children without recorded ages were allocated the mean age of 7.64 years (SD 4.89). There were 69 family groups (at least one adult and one child) with 36.7% of children in single-parent families, and 29.3% with two parents. A further 3.6% are identified with three adult carers, presumably grandparents or aunts. Number of children ranged from one to six per family, with 39.9% of families having one or two children. The mean length of time in detention for all adults and children was 209.5 days (7 months), with a range of 90 to 390 days and SD of 62.36. This includes infants born into detention.

also indicate data entry errors. Oral translation of English language self-report measures by interpreters may have altered reporting. There are also minor age variations in versions of the SDQ, and in the disorderly circumstances, these were used randomly for children aged 3-17.

Statistical analyses

Demographic data was collated. K10 and SDQ data was entered into a database with incomplete data excluded. Total problem and specific symptom scores were analyzed. The SDQ was scored assuming parent report and analyzed using 5-factor analysis. Parent concerns in response to specific questions about infants were collated. Descriptive analysis of socio-demographic characteristics and mental health outcomes was undertaken to assess bivariate associations between parent and child indices. Multilevel analysis based on Actor-Partner Interdependence Model (APIM) and structural equation modelling was applied to examine for dyadic associations between parent and child outcomes.

Results

Kessler 10

There were 166 complete K10s: 139 for adults and 26 for teenaged children (aged 12-17). The prevalence of mental disorders was determined using the National Survey of Mental Health and Well-Being likelihood bands.[40] (Table 2). These results indicate very high rates of severe distress, with 83% of adults and 85.7%

Table 2: K10 results

	N	Percentage (%)
Parents/Carers	Total = 131	
Likely to be well (score <20)	1	0.7
Likely to have mild mental disorder (20-24)	9	6.9
Likely to have moderate mental disorder (25-29)	12	9.2
Likely to have severe mental disorder (30 or over)	109	83.2
Children (12-17 years)	Total = 35	
Likely to be well (score <20)	1	2.9
Likely to have mild mental disorder (20-24)	3	8.5
Likely to have moderate mental disorder (25-29)	1	2.9
Likely to have severe mental disorder (30 or over)	30	85.7

Table 3: K10 Anxiety/Depressive symptoms

Parent/Carer N=131 (P) Children 12-17 years N=35 (C)	P	C	P	C
Anxiety symptoms	None (%)		Most/All (%)	
Feeling nervous	12.2	5.7	87.8	94.3
Feeling so nervous that nothing could calm them down	13	14.3	87	85.7
Feeling restless or fidgety	14.5	8.6	85.5	91.4
Feeling so restless that they couldn't still	17.6	8.6	82.4	91.4
Depressive symptoms				
Feeling depressed	0.8	2.9	99.2	97.1
Feeling so sad nothing could cheer them up	3.1	2.9	96.9	97.1
Feeling that everything was an effort	7.6	5.7	92.4	94.3
Feeling worthless	9.9	8.6	90.1	91.4
Feeling tired out for no good reason	11.5	5.7	88.5	94.3
Feeling hopeless	13	5.7	87	94.3

of teenagers indicating severe disorder. Symptom responses were ranked highest to lowest with adolescents most often reporting *depressed, hopeless, and worthless*, while for adults it was *depressed, worthless, and tired for no good reason*. When K10 items for anxiety (items 2, 3, 5, 6) and depression (1, 4, 7, 8, 9, 10) were scored (Table 3), all participants met criteria for mixed anxiety and depression. The K10 does not enable PTSD to be differentiated.

Strengths and Difficulties Questionnaire (SDQ)

There were 70 complete SDQ for children aged 3-17. The age distribution shows 52 (74%) aged 3-11 and 18 (26%) aged 12-17. Although it is likely some SDQ for adolescents were self-reported, this cannot be distinguished and all were scored as parent-reported. Strong correlations have been found between self- and parent-reported SDQ in one study of refugee children.[41] Fifty percent of children had abnormal total difficulty scores and another 25.7% had borderline scores; in total, 75.7% of children had a high probability of psychiatric disorder (Table 4) Symptom distribution by five-factor analysis showed high rates of emotional symptoms with 71.5% abnormal and another 7.1% with borderline emotional symptom scores, indicating 78.6% of children had significant emotional symptoms. Conduct scores were lower with 39.85% of children with borderline or high conduct symptoms, 48.6% had borderline or high hyperactivity scores and 55.7% had abnormal peer problem scores. Prosocial behaviors were abnormal in 32.9% of children.

Infants and young children (aged 0-4)

The AHRC questionnaire asked: *Do you think your child's emotional and mental health has been*

Table 4: SDQ Scores

SDQ scores	N=70	Percentage (%)
Total difficulties score		
Abnormal (>17 total score)	35	50
Borderline (14-16 total score)	18	25.7
Normal (0-13 total score)	17	24.3
Emotional symptoms score		
Abnormal	50	71.5
Borderline	5	7.1
Normal	15	21.4
Conduct problems score		
Abnormal	25	35.7
Borderline	6	8.6
Normal	39	55.7
Hyperactivity score		
Abnormal	25	35.7
Borderline	9	12.9
Normal	36	51.4
Peer problems score		
Abnormal	12	17.1
Borderline	27	38.6
Normal	31	44.3
Prosocial behavior score		
Abnormal	16	22.9
Borderline	7	10
Normal	47	67.1

affected by being in detention? and *Do you have concerns about your child's development?* Responses and specific concerns were collated for the 48 children under five. (Table 5) Thirty-two (67%) parents identified concerns about the impact of detention on their infant's emotional or mental health and 11 (23%) identified concerns about development. The most frequent were socio-emotional symptoms including *nightmares and sleep problems, always worried, upset or sad, fighting with others, restless, agitated*. The most frequent developmental concern was *poor eating/low weight gain*.

Correlations

This study did not find correlations between length of detention and severity of psychological distress for adults or children. (Table 6) Nor were there significant associations within families between parent K10 and paired children's SDQ scores.

Discussion

Despite many limitations, this sample is arguably worth analysis and reporting because of the extremely limited health data about detained children and parents, the human rights implications of

TABLE 5: Concerns about infants and young children (aged 0-4)

Has your child's emotional and mental health been affected by detention?	
Yes	32 (67%)
No	2
No answer/not sure	14
Do you have concerns about your child's development?	
Yes	11 (23%)
No	4
No answer/not sure	33
Total	48
Specific concerns (ranked)	
Nightmares, sleep problems	18
Always worried/upset/sad	15
Fighting with others	10
Restless, agitated	8
Anxious, clingy, won't leave room	7
Poor eating/low weight gain	6
Not socializing	5
Not able to play or learn	4
Nail-biting/headaches/other	4
Toileting/constipated	3
Bedwetting/incontinent	3
Always shouting/ screaming	2
Self-harming/head banging	2
Not talking	2
Not crawling/walking	1

TABLE 6: Correlations

Correlations *LOD = Length of detention		Sig Value
Between child K10 and LOD*	Non-sig >.05	0.881
Between adult K-10 and LOD	Non-sig >.05	0.549
Between child SDQ and LOD	Non-sig >.05	0.223

the findings, and the impossibility of undertaking this research in conventional ways. It provides data on rates of probable mental illness, allows some description of symptom profiles, and attempts examination of data within families. Bias in the data is potentially in either direction, with under- or over-reporting of distress. It is of significant public interest that the mental health and human rights consequences of this aspect of Australian government policy are analyzed and reported in standardized, measurable ways.

As this study and the government's own data show, immigration detention has severe health and mental health consequences for the majority of detained adults and children. Rates of psychiatric disorder in the CI sample on the K10 dramatically exceed the 12-month prevalence in the general Australian population where affective disorders have a prevalence of 6.2% with 4.1% for depressive disorder, and anxiety disorder prevalence is 14.4% with PTSD at 6.4%.[42] Rates greatly exceed those reported in a large international meta-analysis of mental health of refugees and conflict-affected people, which found a prevalence of 30.8 % for depression and 30.6% for PTSD.[43] There is evidence of the adverse effects of detention on mental health post-release, but very little data on the mental health of currently detained asylum seekers. A small Australian study of detainees from one ethnic group using other standardized self-report measures found very high rates similar to this study, with 100% of detained adults meeting criteria for major depression and 86% diagnosed with PTSD.[44]

The high SDQ total problem scores for children in this sample more closely resemble Australian clinical than community populations. Rates of mental disorder in community samples are between 9% and 14%, while a study of 130 children referred to a mental health service (CAMHS) identified 85% of children with borderline or abnormal behavioral/emotional symptoms on SDQ.[45] High symptom scores in the CAMHS group showed 72% emotional, 78% conduct, 60% hyperactivity/inattention, 64% peer relationship problems with low prosocial scores in 38%.[46] Overall problem scores are similar (75.7% of the CI sample and 85% of the clinical group) with notably lower rates of conduct (38.9% compared with 78%) and hyperactivity/inattention (46% versus 60%) symptoms than the clinic population.[47]

Distress in the CI sample was higher than in children held in open European asylum centers or in the UK community. A study of 267 asylum seekers' children in open centers in the Netherlands found 50% of children aged 4-11 with significant symptoms, 38% in the abnormal range and 12% at borderline levels. Factors such as maternal mental health, parental loss, and family size were more important than length of detention.[48] A Danish study found that 26% of 246 children living with their families in open centers scored above caseness on total scores; 50% had significant emotional problems, 18% raised hyperactivity scores, 11% conduct problems, and 19% peer problems. Only 3% had abnormal pro-social scores.[49] A UK study of community-based migrant and refugee children using the SDQ found that 27% of refugee children, 9% of ethnic minority children and 15% of white children met case criteria.[50] Refugee children showed particular difficulties in emotional symptoms, consistent with the current study. Parents reported significant concern about their infants, and this vulnerable group deserves more attention in studies of displaced populations.

The lack of correlation between distress and time detained may represent a ceiling effect given the significant period detained and the pervasively high distress levels. The lack of correlation between parent and child distress may be explained by the statistical method (pairing one child with one parent). This is an inadequate measure of children's exposure to adult mental illness or disturbed family relationships. In closed detention, many interacting factors in the institutionalized environment alter family functioning and therefore the quality of parent-child interactions. In addition, children were in constant proximity to many adults, 83% of whom were likely to have a severe mental disorder. Potential protective factors outside the family, such as schooling, were largely absent. The available data does not enable analysis of children's exposure to specific or cumulative risks, including factors prior to their detention by Australia.

It is important to acknowledge that K10 scores indicate 14.3% of teenaged children and 17% of adults without significant symptoms. On SDQ, almost a quarter of children were not rated as of concern. There is no information, including about family factors, which might account for apparent resilience or under-reporting in adverse circumstances. Studies of refugees in the community identify belief systems, social support, and a range of psychological strategies as important, but literature on resilience and coping in detained child and adult asylum seekers is limited.[51] The UN General Assembly Human Rights Council recently re-affirmed "The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and emphasizing that mental health is an integral part of that right."[52] The harms caused to child and adult asylum seekers are no longer denied by the Australian government, and instead repeatedly justified on the grounds of deterrence.[53] The use of mistreatment as deterrent contravenes the 1985 United Nations High Commission for Refugees (UNHCR) Guidelines on the Detention of Asylum Seekers, which explicitly state that this is contrary to the principles of international protection.

Conclusion

This study adds to the scientific literature, witness reports, and the Australian government's own evidence of the profound negative consequences of detaining asylum-seeking children and families. There are few studies of families during prolonged immigration detention and fewer that include children under 5 years. A majority of parents had concerns about their infant's health and /or development. K10 and SDQ scores indicate extreme rates of psychological distress and probable disorder in children and adults and teens with co-morbid anxiety and depression at clinical levels. Detention may have specific psychological impacts on children, resulting in higher rates of emotional symptoms but lower hyperactivity and conduct scores than in clinical groups. The profound access limitations and lack of independent health care provision and monitoring make detailed analysis of potential contributing and cumulative risk factors impossible.

Australia's current immigration policies violate detainees' human rights in multiple ways, including their right to health, by causing severe psychiatric distress and disorder in adults and children. Untreated or inadequately treated mental illness has ongoing consequences and increases the risk of self-harm and suicide. This has implications for the immediate and longer-term care of asylum seekers and further highlights the harm caused. The acknowledged methodological limitations of the study are a consequence of the practical, political and ethical obstacles to undertaking research in conventional ways with this extremely vulnerable population. Australia's harsh immigration and border protection regime is maintained and defended in callous disregard for the people who are harmed. Justification on the basis of deterrence represents a further breach of our humanitarian obligations, raising concern that these practices amount to torture of those detained indefinitely. The findings of this study have scientific, human rights, and undeniable political implications.

Acknowledgments

This work is possible because the Australian Human Rights Commission (AHRC) collected the primary data, which was subsequently released under Freedom of Information legislation (FOI). Australian Government data about the mental health of detained asylum seekers was obtained under FOI by the Guardian newspaper. Any errors or omissions are the sole responsibility of the author.

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Paper 6

Zwi, K., Mares, S., Nathanson, D., Tay, A. & Silove, D. (2018). The impact of detention on the social-emotional wellbeing of children seeking asylum: A comparison with community-based children. *European Child & Adolescent Psychiatry*, *27*:4, pp. 411-22

This cohort comparison study compared data from the SDQ for 48 children aged 4–15 years who were detained on Christmas Island and reported above (Mares, 2016b) with SDQ data from a comparable sample of 38 refugee children resettled in the Australian community under the UNHCR resettlement program. This 'community sample' had never been detained and were part of a longitudinal follow-up study (Zwi, Rungan, Woolfenden, Woodland, Palasanthiran & Williams, 2017). The comparison study was a rare opportunity to compare, and the first published comparison of these matched cohorts of detained and resettled refugee children, who can be presumed to have similar pre-migration risks. Both sample populations are small, and the data is limited to SDQ data and demographic information. Although I was second author, I made a substantial contribution to the study and the paper, which could not have been undertaken without the secondary data from Christmas Island as outlined in Paper 5. My contribution can be summarised as 40% of research design, 50% of data collection and 30% of writing and editing. The paper is reproduced with permission.

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ORIGINAL CONTRIBUTION

The impact of detention on the social–emotional wellbeing of children seeking asylum: a comparison with community-based children

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Abstract

Accumulating literature demonstrates that immigration detention is harmful to children. However, there is a scarcity of scientifically rigorous and reliable data about the health of children held in detention facilities. The aim of the study was to compare a community-based population of recently arrived refugee children flown into Australia, not detained, resettled in a non-urban area, with a population of children who arrived by boat seeking asylum, detained since arrival. The parent-version of the strength and difficulties questionnaire (SDQ) of children aged 4–15 years was compared in children living in the community with those held in detention. We compared 86 children who had a parent-completed SDQ performed, 38 (44%) in the community group and 48 (56%) in the detention group. The community sample had been living in Australia for 325 days, with no time in detention. The detention sample had been living in detention for a mean of 221 days. The mean age was similar for the community and detention sample at 8.4 years ($P = 0.18$). In the total sample, children in the detention group had significantly higher SDQ total difficulties scores than children in the community group ($P < 0.0001$). There was no difference between age groups ($P = 0.82$). The children in the detention group had, on average, an SDQ total difficulties score that was 12 points higher than children in the community group. Four of the five SDQ subscale scores indicated greater disturbance amongst children in detention (< 0.0001) compared to children living in the community. The detention group had significantly higher scores ($P < 0.001$) for all except Pro-social scores as compared to Australian norms for the 4–6 and 7–15 years age group. This study presents a rare opportunity to compare the wellbeing of displaced children who were detained following arrival in Australia with those settled in the Australian community since arrival. The community children's scores approximated data from the general Australian childhood population. Children held in detention had significantly more social, emotional and behavioural difficulties than children living in the community, and at levels resembling a clinical cohort. Despite the small sample size, data restrictions and other limitations of the data, statistical significance in differences between the community and detention children is marked and arguably demonstrates the negative impact of post-arrival detention in children who are presumed to have similar levels of pre-arrival adversity. If the objective is to optimise the health and wellbeing of children seeking asylum, removal of post-arrival detention is one of the most powerful interventions available to host countries.

Keywords Refugee · Asylum seeker · Children · Detention · Social–emotional wellbeing · Strengths and difficulties questionnaire (SDQ)

This article is part of the focused issue 'Mental health issues in refugees'.

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Introduction

According to the United Nations High Commission for Refugees (UNHCR), the world is witnessing the highest level of forced population displacement on record. The estimated 65.3 million people around the world who have fled their homes include 21.3 million formally recognised as refugees by the UN. Importantly, half of all refugees are children under the age of 18 years [1]. There is a remarkable convergence in the findings of extant studies in identifying a consistent profile of risk factors for poor health and wellbeing outcomes for refugee children. These include female gender, unaccompanied child status, time held in immigration detention centres, pre-migration and/or postmigration exposure to violence, family separations, psychological morbidity amongst carers, negative school and peer experiences, perceived discrimination, parental unemployment, reduced family socio-economic status and ongoing financial stress [2–10]. Reducing the time held in immigration detention centres may be one of the risk factors most amenable to public health interventions, particularly in reception countries of the west.

Recipient nations have shown increasing reluctance to provide protection to those seeking asylum with restrictive immigration practices being driven by policies of so-called ''humane deterrence'', despite evidence that these policies cause harm to children and adults [11–15]. Relevant policies include the confinement of asylum seekers, including children, in immigration detention facilities, increased border surveillance, and the outsourcing of procedures for determining refugee status to other countries [12, 13]. The current system in Australia is that 13,000–20,000 refugees each year are resettled in the community after the processing of their protection claims by the United Nations overseas. However, asylum seekers who have not had their claims processed on arrival in Australia and who arrive by boat are routinely subject to mandatory detention, off-shore processing in remote islands and denial of permanent protection, family reunification or resettlement in Australia [16, 17]. The detention of children is not confined to Australia, the practice being applied in more than 60 countries worldwide across the spectrum of high and low income nations, making this an issue of global concern [12].

Logistic and administrative obstacles present formidable obstacles for researchers in obtaining representative samples of asylum seekers. Access to detention centres in remote settings in countries like Australia is made difficult by geographical constraints and administrative provisions that restrict information gathering and dissemination of data by researchers and health professionals. In addition, obtaining informed consent remains a complex challenge given that asylum seekers may perceive participation in research as a threat to achieving positive refugee determinations [11–14, 18–22]. Routine health care within immigration detention centres is largely provided by contracted medical services, reducing the incentive for employees to release health data for fear of adverse employment consequences and, in some countries, there are legal prohibitions against disclosing information [18, 20, 23, 24]. In the case of unaccompanied children, Australian law requires consent to participate in research from their legal guardian, which in this instance, is mandated to be the Minister of Immigration, the state officer who is responsible for the detention policy. As with all studies relating to traumatic stress reactions, retrospective reporting holds the inherent risks of recall bias, and the possibility of either under- or over-reporting of symptoms [14, 23].

Despite these limitations, existing research studies in the field converge to indicate that immigration detention is a cause of psychological harm to both adults and children. Studies in the peer-reviewed literature internationally, including those conducted in the UK, Europe, Canada, Japan, the USA and Australia, consistently show high rates of mental distress amongst children who have been detained [11, 13, 18, 19, 21, 23–31]. Well documented reactions amongst detainees include depression, anxiety, posttraumatic stress disorder (PTSD), fear and hopelessness, responses that are accompanied by impaired functioning. Rates of emotional disturbance vary between a third and four fifths of detained children across studies [11–13, 18–20, 22, 24, 25, 32]. In addition, detention has negative impacts on children's physical health and developmental progression [11, 20, 25].

The longer the period of detention, the greater the risk of adverse mental health outcomes [14, 15, 20, 24, 33, 34]. However, even brief periods of detention may be harmful [19, 25]. Children are detained in Canadian and British detention centres for far shorter periods (mean of 43–56 days) than was the case in Australia (16–20 months) at the time of this study, and had high rates of emotional distress, behavioural difficulties, depression, anxiety, sleep problems, somatic complaints and symptoms of PTSD, even if they did not report exposure to physical violence or deprivation [15, 19, 25, 32]. Similarly, in Sweden, regarded as providing better detention standards than many other nations, detainees including children reported lower quality of life than newly settled refugees in the community [28]. This suggests that even short periods of detention under relatively 'safe' conditions may be damaging for asylum seeker children [19].

Including a group for comparison represents an important methodological improvement in studies examining the psychological status of detained refugee children, an approach that has been pursued in studies amongst adult

asylum seekers. Robjant [21] compared levels of psychological distress in asylum seekers in the community with the same indices in detained asylum seekers and non-refugee criminal detainees. The researchers found that asylum seekers in detention had the highest scores of all three groups on depression, anxiety and PTSD symptoms. Ichikawa [27] also found that ex-detained adult asylum seekers had higher levels of emotional disturbance once released than their refugee counterparts who had never been detained. Cohen [23] found suicide and self-harm rates in asylum seekers in UK detention centres to be higher than those amongst refugees in the community and comparable to the prevalence amongst general prison populations. To date, there are no published studies comparing asylum seeker children in detention with children in the community in relation to indices of mental health and wellbeing.

These considerations prompted the present study. We recognised at the outset that there were substantial methodological constraints in comparing children in detention and in the community given that the sampling frames could not be matched precisely. Nevertheless, we included a community sample in this analysis to provide a broad yardstick of the level of mental disturbance amongst refugee children in Australia who had not been detained. Our aim was to examine whether, as hypothesised, refugee children in detention showed poorer levels of social–emotional wellbeing than their counterparts living in the community. The samples included a community-based population of refugee children who arrived by plane, were not detained, were allowed to reside in a non-urban area and followed for 2–3 years after arrival; and the index group of children who arrived by boat seeking asylum, were immediately detained and held in detention for the duration of their residency in Australia.

Methods

The two populations from which our samples were drawn are described in detail below.

Community population

Between 2009 and 2013, a population cohort of all newly arrived refugee children settled in a non-urban area were visited at home by nurses shortly after arrival in Australia, and their families were invited to participate in a prospective longitudinal study [35]. Recruited children had health and wellbeing assessments conducted at year 2 (average 13 months) and year 3 (average 31 months) post-arrival. During the specified timeframe, 228 refugee children arrived in the study region, 158 meeting the eligibility criteria (aged 6 months to 15 years), of whom 61 (39%) were recruited to the study. Fewer children were initially recruited than anticipated due to logistic difficulties (unavailability of language interpreters when needed) (n = 52;33%), families/children declining to participate (n = 24;15%), relocation out of the area (n = 13;8%), or not contactable (n = 8;5%).

Of those recruited, 43 were eligible to complete the main mental health assessment measure, the strengths and difficulties questionnaire (SDQ—described below) (for ages 4–15 years) and parents completed the parent-report version in 38 of 43 (88%) children at year 2 of follow-up. Face-to-face interpreters were used during all assessment interviews; translated versions of the SDQ were used for literate Arabic and Farsi speaking participants. SDQ scores in the study children were compared to Australian normative data.

The community sample consisted of 48% male and 52% female children. Children's families originated from the South East Asian (29%), African (20%) and Eastern Mediterranean (13%) World Health Organization (WHO) designated regions. On arrival, 30% of children were living in single-parent families. Other population characteristics, physical and developmental health and predictors of social–emotional wellbeing are described elsewhere [35–37]. The children retained in the study (85%) over 2–3 years were similar to those not recruited and lost to follow-up in terms of gender, WHO region of origin and language spoken at home [35].

Detention population

Data for detained children were collected in March 2014 during the Australian Human Rights Commission (AHRC) National Inquiry into Children in Immigration Detention [38]. Some of the authors (KZ and SM) were invited as consultants to the AHRC Inquiry and were involved in the design of the inquiry methodology including selection of the SDQ and other indices of data collected during the visit to Christmas Island. The data collected were later obtained for analysis under Freedom of Information (FOI) legislation in July 2015; the main findings have been published elsewhere [18]. At the time, 356 children aged 0–17 years were held in detention on Christmas Island, a remote Indian Ocean island which forms part of Australia situated off the northwest coast of the mainland. The AHRC provided data relating to 365 people under FOI, which included adults and children in 69 family groups (at least one adult and one child) with 37% of children in single-parent families; 29% had two parents and 4% were with other adult carers. The number of children ranged from one to six per family, with 40% of families having one or two children. The 191 children in the dataset represent 48% of the 356 children detained at the time on Christmas Island. Time in detention and ages of children were provided for most children. Information concerning gender, individual country of origin, and language group of child was redacted to protect participants and therefore are not available for analysis. However, accessible data indicate

that the whole population of children in detention at the time (1089 children) were of Eastern Mediterranean (50%), South East Asian (18%), Western Pacific (12%), African (< 1%) and 'Stateless' (19%) origin. Complete SDQ data were available for 70 children (20%) aged 3–17. The English language parent-report version of the SDQ was completed during interview with parents and children using face-to-face interpreters.

Inclusion criteria for the study sample

In order to increase comparability of the two populations, we selected children aged 4–15 years. This meant exclusion of SDQ data for children under 4 and aged 16–17 years from the detention sample, reducing the detention sample from 70 to 48 children. We compared the year 2 SDQ assessment of the community sample with the SDQ assessments of the detention sample.

Measures

The SDQ was selected as a tool with high sensitivity and specificity and validated in past studies for assessing social–emotional wellbeing across cultures and in migrant and refugee children [39–42]. It includes 25 items with five symptom scales (Hyperactivity–inattention, Emotional symptoms, Peer problems, Conduct problems and Pro-social behaviour), all of which except the Pro-social subscale were used to produce the total difficulties score; the impact supplement was not used [43]. Psychometric studies have attested to the robustness of the measure for diverse populations around the world including Australia [41]. Means and standard deviations for each subscale and total difficulties scores are available for the Australian population [43]. In population and clinical studies, high SDQ scores are routinely used to indicate increased risk of mental illness [39, 40].

Statistical methods

The SDQ total difficulties score was calculated using the usual procedure which includes four subscales but not Pro-social subscale. Depending on the analysis, the SDQ total difficulties score was treated as either a continuous variable, or categorised into: (1) normal and (2) borderline and abnormal. Categorical data were described according to frequencies and percentages and differences in these indices between community and detention children were examined using contingency tables with Pearson's Chi-square. Test statistics are reported with degrees of freedom (*DF*). Two-way analysis of variance was used to examine differences in mean SDQ total difficulties scores between age groups and community and detention children with least significant difference post hoc tests used to generate mean differences and 95% confidence intervals (95% CI). Independent sample *t* tests were used to compare the mean values of the SDQ domains between the community and detention samples with non-parametric Mann–Whitney *U* tests used to validate *P* values where the data were non-normally distributed. Two-tailed tests were used and *P* values < 0.05 were considered statistically significant. Study data were compared with normative Australian data for the SDQ [43–45]. Data were analysed using SPSS version 22.0 [IBM, USA].

Results

The study sample comprised a total of 86 children aged 4–15 years who had a completed SDQ, 38 (44%) of whom were in the community group and 48 (56%) in the detention group (Fig. 1).

Time in the community or in detention

The community sample had lived in the community since arrival in Australia for an average of 325 days (11 months; range 161–727 days or 5–24 months). Of the children in

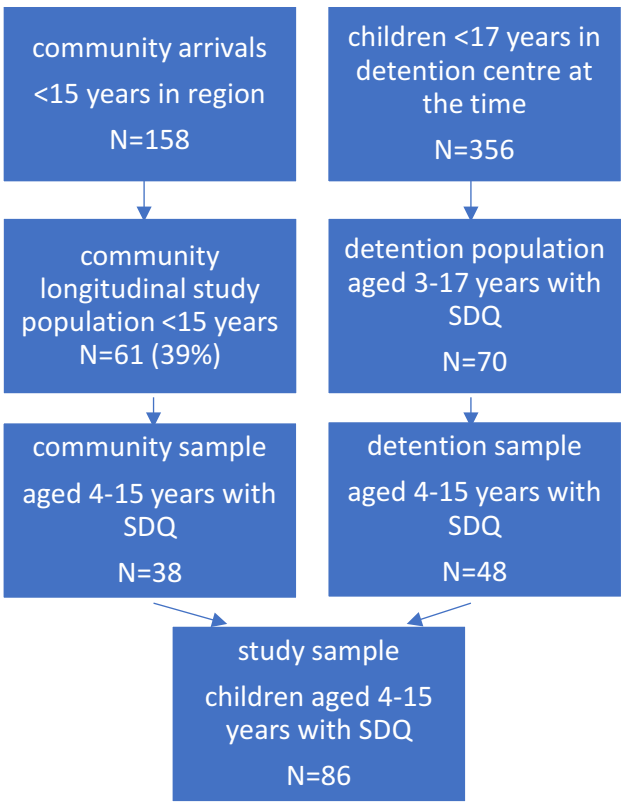

Fig. 1 Formation of study sample ($n = 86$)

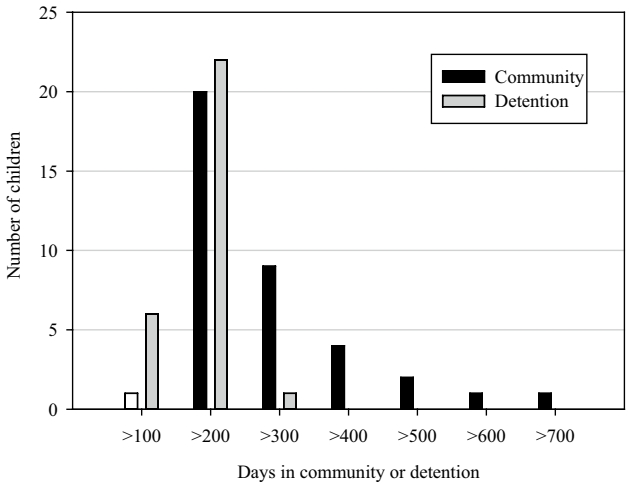

Fig. 2 Number and distribution of days in the community and in detention for the community sample ($n = 38$; mean = 325 days) and the detention sample ($n = 29$; mean = 221)

Table 1 Age group distribution in the community and detention children

	Community (%)	Detention (%)	Total (%)
Age			
4–5 years	9 (24)	6 (13)	15 (18)
6–10 years	18 (47)	32 (67)	50 (58)
10–15 years	11 (29)	10 (21)	21 (24)
Total	38 (44)	48 (56)	86 (100)

the detention sample, only 29 (60%) had time in detention data, with a mean stay of 221 days (7 months) in detention (range 90–390 days or 3–13 months) (Fig. 2). This was not significantly different from the mean length of time that the total population of children aged 0–17 years had spent in immigration detention on Christmas Island (222 days), or the population of children detained elsewhere in Australia at that time, which was 231 days [38, 46].

The sample of children in the community had resided for a longer period in Australia than those in detention, with a mean difference of 104 days (95% CI 61, 149; $P < 0.0001$).

Age distribution

Although the detention sample included a lower percentage of pre-school children, the overall age profile for the community and detention sample was similar ($P = 0.18$), with a mean of 8.4 years (Table 1).

SDQ scores

For the total samples and all age bands within them, children in the detention group had significantly higher SDQ total difficulties scores than children in the community group ($F = 66.9$; $P < 0.0001$) (Table 2). Specifically, the children in the detention group had an average SDQ total difficulties score that was 12 points higher than the average for children in the community group. Analysis of variance showed a significant difference between the two groups ($P < 0.0001$). As can be seen, there was no overlap in mean SDQ total difficulties scores with 95% CIs by age group in the two groups (Fig. 3). There was also no difference in SDQ total scores between groups according to age bands ($P = 0.82$).

In addition to the mean SDQ total difficulties scores, four of the five subscale scores indicated greater levels of disturbance amongst children in detention compared to children living in the community ($P < 0.0001$) (Table 3). The community children's scores on SDQ subscales approximated data from the general Australian childhood population, where rates of mental disorder are between 9 and 14% [44, 45].

The detention group had significantly higher scores ($P < 0.001$) for all except for the Pro-social scale when compared to Australian norms for the 4–6 and 7–15 year age group [43–45, 47] (Table 4).

Represented graphically, the most striking differences are evident in Emotional problems and total difficulties (Fig. 4).

Considering the proportion of children in the abnormal, borderline and normal range of SDQ scores, a higher proportion of detention children had abnormal total difficulties scores (54.2 vs. 13.2%) and a small proportion normal scores (20.8 vs. 76.3%) ($P < 0.0001$) (Table 5). For all subscale scores except Peer Relations, detention children had a higher proportion with abnormal and borderline scores and a lower proportion with normal scores ($P < 0.05$). For Peer Relations, a higher proportion of community children had

Table 2 Mean SDQ total difficulties score in children living in the community and children living in detention (with mean difference and 95% CI), by age group

Age group	Community mean (SD)	Detention mean (SD)	Mean difference (95% CI)	*T* value, *DF*	*P* value
4–5 years	8.9 (6.6)	23.0 (8.1)	14.1 (5.9, 22.3)	3.7, 13	0.003
6–10 years	8.7 (7.3)	20.5 (6.7)	11.7 (7.6, 15.9)	5.7, 48	< 0.0001
11–15 years	8.4 (6.5)	21.7 (7.5)	13.3 (7.0, 19.7)	4.4, 19	< 0.0001
Total sample	8.7 (6.7)	21.0 (7.0)	12.4 (9.4, 15.4)	8.3, 84	< 0.0001

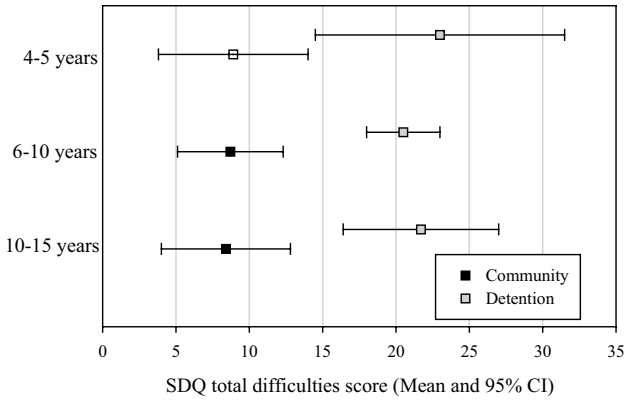

Fig. 3 Mean SDQ total difficulties scores in children living in the community and children living in detention, by age group

abnormal (21.1 vs. 18.8%) but also normal scores (63.2 vs. 37.5%), and lower borderline scores (15.8 vs. 43.8%).

The difference between community and detention children's subscale scores is most striking for Emotional, Hyperactivity and Conduct Disorder subscales, where the difference between the proportion normal between the two groups is 55, 39 and 30%, respectively. The least difference is in Peer relations, at 26% difference. All differences between the two groups are statistically significant ($P < 0.05$).

In the 29 (60%) detained children with available data, there was no correlation between SDQ scores and days in detention ($r = 0.004$; $P = 0.98$) for SDQ total difficulties score.

Table 3 Mean SDQ total difficulties and subscale scores in children living in the community as compared with children in detention (with mean difference and 95% CI), age 4–15 years

	Community mean (SD)	Detention mean (SD)	Mean difference (95% CI)	*T* value, *DF*	*P* value
Conduct disorder	1.4 (1.7)	4.0 (2.6)	2.5 (1.6, 3.5)	5.2, 84	< 0.0001
Emotional problems	2.4 (2.3)	7.4 (2.3)	5.0 (4.0, 6.0)	10.1, 84	< 0.0001
Hyperactivity	2.8 (2.4)	5.8 (2.6)	3.0 (1.9, 4.1)	5.4, 84	< 0.0001
Peer relations	2.1 (1.8)	3.9 (2.0)	1.8 (1.0, 2.6)	4.3, 84	< 0.0001
Pro-social	8.2 (1.9)	6.8 (3.0)	− 1.4 (− 2.5, − 0.3)	2.5, 84	0.01
Total difficulties	8.7 (6.7)	21.0 (7.0)	12.4 (9.4, 15.4)	8.3, 84	< 0.0001

Table 4 Mean SDQ total difficulties and subscale scores in children living in the community and in detention (with mean difference and 95% CI), and Australian normative data (age 4–6 years from Kremer, age 7–15 years from SDQ website)

	Aust norms mean (SD)	Community mean (SD)	*T* value, *DF*	*P* value*	Detention mean (SD)	*T* value, *DF*	*P* value**
Age 4–6 years							
Conduct disorder	1.2 (1.4)	1.3 (1.6)	0.2, 14	0.87	5.6 (2.7)	5.3, 10	< 0.0001
Emotional problems	1.4 (1.6)	2.1 (2.2)	1.2, 14	0.26	7.0 (2.6)	7.0, 10	< 0.0001
Hyperactivity	2.8 (2.2)	2.5 (2.4)	− 0.5, 14	0.60	7.1 (2.6)	5.4, 10	< 0.0001
Peer relations	1.2 (1.5)	1.9 (2.0)	1.3, 14	0.22	3.4 (1.5)	4.8, 10	0.001
Pro-social	8.2 (1.8)	8.4 (1.5)	0.5, 14	0.63	4.6 (3.0)	− 4.0, 10	0.003
Total difficulties	6.5 (4.7)	7.7 (6.7)	0.7, 14	0.51	23.0 (7.4)	7.4, 10	< 0.0001
Age 7–15 years							
Conduct disorder	1.5 (1.6)	1.5 (1.7)	0.1, 22	0.95	3.5 (2.4)	5.1, 36	< 0.0001
Emotional problems	2.1 (2.0)	2.6 (2.4)	1.0, 22	0.35	7.5 (2.2)	14.8, 36	< 0.0001
Hyperactivity	3.1 (2.4)	3.0 (2.5)	− 0.1, 22	0.91	5.4 (2.6)	5.6, 36	< 0.0001
Peer relations	1.6 (1.9)	2.2 (1.7)	1.6, 22	0.12	4.0 (2.2)	6.9, 36	< 0.0001
Pro-social	8.3 (1.7)	8.0 (2.2)	− 0.7, 22	0.51	7.4 (2.8)	− 2.1, 36	0.05
Total difficulties	8.2 (6.1)	9.3 (6.9)	0.8, 22	0.45	20.5 (6.8)	10.9, 36	< 0.0001

* Difference between the community sample and Australian norms

** Difference between the detention sample and Australian norms

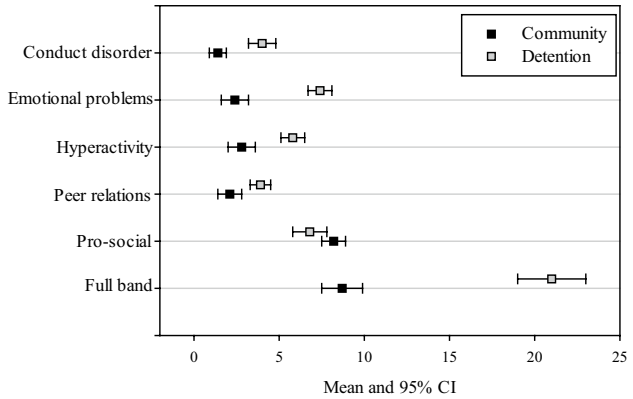

Fig. 4 Mean and 95% CI of each SDQ total difficulties (full band) and subscale score in the community and detention group

Discussion

This study presents a rare opportunity to compare the wellbeing of asylum seeker children living in detention and refugee children living in the community since arrival in Australia. Children in the detention group had significantly impaired social–emotional wellbeing represented by higher SDQ total difficulties scores than children in the community group, both in the respective samples as a whole and across all age groups. The social–emotional wellbeing of community refugee children approximated Australian normative data [43, 45] and were similar to findings amongst 530 refugee children and adolescents living in the South Australian community [47, 48]. Consistent with existing evidence about the harms caused by immigration detention, over half the children living in detention had SDQ scores significantly in excess of the normal range for the total difficulties score and four of the five SDQ subscales across all age groups. The detention children in our study also had a higher proportion of abnormal SDQ total scores (54%) compared with asylum seeking children detained in open centres in Denmark (31%) [49] and the Netherlands (38%) [50].

The SDQ subscale scores were significantly worse for detention children compared to community children for all except the Pro-social subscale. The subscale scores demonstrated greatest difficulties for detained children in the domains of Emotional problems, Hyperactivity and Conduct Disorder. This distribution of problems resonates with other studies of detained children [49]. SDQ measurement of Emotional problems (indicated by the child often complaining of headaches, and being fearful, unhappy and nervous in new situations), Hyperactivity (restless, easily distracted and impulsive with difficulties concentrating) and Conduct Disorder (easily angered, disobedient, fights with other children, and often lies, cheats and steals) indicates that children are significantly symptomatic across multiple domains of functioning, consistent with clinical observations and other studies of detained children [11–13, 18–20, 22, 24, 25, 32].

For both our community sample and the South Australian refugee children, scores on Peer Relations were relatively more problematic than in the detention children [48]. The Peer Relations subscale includes indicators that the child has few friends, is bullied and gets on better with adults than same aged peers. This may reflect conditions in the community where refugee children experience difficulties integrating into mainstream society in their first year of settlement. Other studies have shown that this initial impediment improves over time and is no longer problematic by the third year of settlement [36].

The only subscale in which detention children had better mean scores than community children was the Pro-social subscale. This measures whether the child is considerate of other people's feelings, shares readily with others, is helpful if someone is hurt, kind to younger children and volunteers to help others. Increases in Pro-social scores have been found in studies of children of parents with mental illness in the general community [51]. It is well documented that there

Table 5 Children with abnormal, borderline and normal SDQ scores in the community and detention groups

	Community			Detention			Chi-square value, *DF*	*P* value
	Abnormal *N* (%)	Borderline *N* (%)	Normal *N* (%)	Abnormal *N* (%)	Borderline *N* (%)	Normal *N* (%)		
Conduct disorder	5 (13.2)	1 (2.6)	32 (84.2)	19 (39.6)	3 (6.3)	26 (54.2)	8.7, 2	0.013
Emotional problems	9 (23.7)	1 (2.6)	28 (73.7)	36 (75.0)	3 (6.3)	9 (18.8)	26.1, 2	< 0.0001
Hyperactivity	3 (7.9)	2 (5.3)	33 (86.8)	21 (43.8)	4 (8.3)	23 (47.9)	15.0, 2	0.001
Peer relations	8 (21.1)	6 (15.8)	24 (63.2)	9 (18.8)	21 (43.8)	18 (37.5)	8.2, 2	0.017
Pro-social	0 (–)	2 (5.3)	36 (94.7)	12 (25.0)	5 (10.4)	31 (64.6)	12.7, 2	0.002
Total difficulties	5 (13.2)	4 (10.5)	29 (76.3)	26 (54.2)	12 (25.0)	10 (20.8)	26.7, 2	< 0.0001

are high rates of mental illness and psychological distress in adults living in detention [15, 18, 20, 23, 51]. We hypothesise that Pro-social skills may be required for survival and wellbeing in children living in difficult circumstances, especially if the adults around them are not able to adequately respond to their needs. As these children were living in close proximity to similarly detained children from comparable circumstances and with whom they could potentially identify, their capacity for kindness to other children may have been promoted and reflected in the Pro-social score. They also may have had reduced exposure to the lack of belonging, discrimination, bullying or exclusion that some refugee children encounter when first settled in the community [36]. Our finding of better mean Pro-social scores for detained children also indicates that there was not uniform reporting of abnormal adjustment, or "plaintive" bias, in response to the SDQ for the detention group.

The total difficulties score on the SDQ is likely to be more accurate and replicable than subscale scores, especially when comparing different ethnic groups [52, 53]. This study found that worse social–emotional wellbeing in children in detention was consistent whether total difficulties scores or subscale scores were considered. Despite the small sample size and other limitations of the data, differences between the community and detention children were substantial and statistically significant, suggesting the negative impact that post-arrival detention has amongst children who are presumed to have similar exposure to pre-arrival adversity.

An important risk factor for poor social–emotional wellbeing is unaccompanied child status [2–10, 54]. Of the 15 unaccompanied children in the detention population, only one was 14 years of age and therefore eligible for inclusion in this study (age range of 4–15 years). The remaining unaccompanied children were 16–17 years of age and were therefore excluded; however, analysis of their SDQ data showed that the older unaccompanied children had the same distribution of total difficulties scores on the SDQ as the rest of the detained sample population.

Limitations

This study has limitations for reasons that were largely unavoidable. Data from the detention sample were cross-sectional, preventing longitudinal analysis which has been possible in the community sample. Because of constraints on assessment and in data release, insufficient information was available to exclude differences in the pre-arrival adversities experienced by the two groups of children, although they are assumed to have faced similar levels of adversity in their countries of origin. The refugee children settled in the community had not experienced the boat journey to Australia that preceded arrival of the detained children. Previous reports indicate that detained children on Christmas Island remained distressed by transit experiences including the boat journey [55, 56]. Conversely, however, the children processed by the UN, flown to Australia and settled in the community are likely to have had longer periods of transit in refugee camps outside Australia while their refugee claims were processed.

The community children had been living in the Australian community longer than the detention children had been detained, with a mean difference of 104 days (3½ months). The higher level of social–emotional wellbeing identified in community children may be a reflection of their longer stay outside of countries of transit and origin. Other studies show that the longer displaced children are in the community in Australia or other host countries, the more their social–emotional wellbeing approximates local norms [36]. However, it is implausible that this difference adequately explains the marked disparity in SDQ scores. Unfortunately, no published literature was identified that would allow a direct comparison between displaced children resettled in the community with the precise post-arrival time period of the detention children in our study.

In the detained children there was no correlation between social–emotional distress (SDQ total score) and time detained despite evidence of an association in other studies [14, 15, 20, 24, 33, 34]. This is most likely due the small sample size of 29 children included in this analysis.

Restricted access to the detained population required that data collection was opportunistic and occurred during a brief period when the authors visited Christmas Island as part of the Australian Human Rights Commission Inquiry in 2014 [38]. The data provided for analysis under Freedom of Information provisions were heavily redacted and excluded data on gender, countries of origin, language group and other factors such as family separation and parental mental health that are known to impact on children's social–emotional wellbeing [2, 4–10, 18, 57–63]. Differences in these characteristics could have accounted in part for the disparity in SDQ scores found between the two samples. For example, in the community sample, although not associated with gender, the SDQ score was related to the presence of the child's father [37]. Notwithstanding the proportion of single-parent families was similar between the community and detention groups. The detention sample comprised a proportionately higher number from the Eastern Mediterranean region and lower proportions from the African region. Origin from the latter region is known to be associated with lower levels of distress amongst children in general, although the literature on the impact of region of origin is inconsistent [4, 7, 8, 37]. In spite of these caveats, the magnitude of the SDQ differences strongly suggests that detention remained a major factor shaping distress amongst children in that setting.

Although the use of a self-report instrument such as the SDQ provides information directly from the parent, and arguably provides a more accurate indication of distress than clinician-rated screening tools, distortions in reporting still may occur in cross-cultural settings arising from differences in understanding underlying concepts of health and illness; fears of mental health stigmatisation; social desirability effects; and levels of literacy [64–66]. The difference in cultural mix of the two samples may have influenced the extent to which these biases were operating in each group.

Levels of distress in parents and children in the detention or community sample may have influenced participation in data collection in either direction, such as inclusion of more children with poor social–emotional wellbeing in one or other sample. Without additional data on the detention population it is difficult to ascertain the extent of that potential bias. The community sample was less likely to be biased in that the study was prospectively designed to include all newly arrived refugee children in a specified geographic location and, to a large extent, achieved this aim [35]. In addition, the recruitment rate was higher in that sample. At minimum, the observation that SDQ total difficulties scores amongst the detention sample (79%) approached the prevalence found in a child and adolescent mental health service (85%) suggests that in at least a substantial subgroup residing in detention, high levels of psychopathology are present [62].

Despite the acknowledged limitations, this study is significant in that it is the first in Australia and possibly worldwide to compare the social and emotional wellbeing of displaced children settled in the community with those detained on arrival in a country of resettlement. The findings are consistent with and add to the evidence of the harms caused by post-arrival detention of displaced children, an issue of substantial public health and human rights interest considering the policies of deterrence pursued by the Australian and other governments worldwide. The Australian Human Rights Commission National Inquiry into Children in Immigration Detention [38] found detention centres to be unsafe places for children, with unacceptable risk of sexual assault, self-harm and suicide, and the stresses of confinement being instrumental in acts of voluntary starvation and hunger strikes in children. Unaccompanied children are consistently identified as a particularly vulnerable group [20, 55, 67]. In spite of the methodological challenges in undertaking studies in this area, the public interest imperative to do so therefore is clear.

Medical professionals in Australia who speak publicly about their experiences working with children in detention were, until a recent legal challenge, subject to potential imprisonment under the Australian Border Force Act of 2015; the "secrecy and disclosure provisions" of these laws remain operational for other professionals including lawyers, teachers, social workers and detention officers. (https://www.legislation.gov.au/Details/C2016C00650) [11, 18, 68–70]. This has led to sustained opposition from a wide range of professional organisations in Australia, the only country where mandatory detention is enshrined in legislation [16, 20, 26, 69, 71, 72]. Professional allegations that detention is tantamount to torture and a 2013 survey showing that over 80% of Australian paediatricians consider that mandatory detention of children constitutes child abuse have failed to alter Australian government policy [20, 69, 73, 74].

Given the present findings, there is a case for ensuring that the same or higher standards are provided in immigration detention centres compared to prisons in relation to accountability of governance structures, quality and independence of health care, access to services, and meaningful activity for children including education [23, 32]. The imperative of such a comprehensive duty of care is magnified for children, given that they have committed no crime and are amongst the most vulnerable and traumatised of our global population.

Conclusions

Australian and international policies increasingly subject displaced children to immigration detention. There are formidable restrictions to undertaking independent research and analysis of the health and human rights impacts of these policies. In this context, the present study adds to the growing body of data concerning the mental health impacts of detention by comparing the social–emotional wellbeing of asylum seeker children living in detention and refugee children living in the Australian community since arrival. Children in detention have markedly worse social–emotional wellbeing at all ages than their community-based counterparts. The detained children's scores resemble a clinical sample of children referred to child and adolescent mental health services while the community-based children resemble Australian community norms. The difference between the two groups of children is significant at a statistical level in spite of the modest sample sizes. When considered in the context of past observations by professionals and human rights groups and the body of scientific research already accrued, our findings add to the case that detention itself most likely contributes to the high levels of social–emotional distress experienced by children held in detention. Clearly, if the overriding objective is to safeguard and promote the health and wellbeing of children seeking asylum, removal of detention provisions may be one of the most powerful interventions available to host countries.

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Compliance with ethical standards

Conflict of interest The authors received no financial support for the research, authorship, and/or publication of this article and have no conflict of interest.

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Ethics The research involving the community sample in this study and the comparison with the detention sample was granted by the Human Research Ethics Committee Northern Hospitals Network, South Eastern Sydney (SES) Illawarra Area Health Service/SES Local Health District (HREC Ref No 09/163). The research involving the detention sample in this study was assessed by the South Western Sydney Local Health District Human Research Ethics Committee (HREC/15/LPOOL/556), which was satisfied with provisions to protect the rights of participants. All participants gave their informed consent prior to their inclusion in the study.

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Additional findings – children's words and drawings

Several of the papers underpinning the thesis incorporate drawings and words from detained children. These are reconsidered here in order to highlight and privilege these direct communications from the children about their lives in detention. The papers include 13 drawings, quotes and a poem from accompanied and unaccompanied children. These were obtained in various ways and under varying circumstances. More detail about the collection, ownership and interpretation of detained children's drawings is included in Appendix F. The images and quotations are considered together and discussed thematically. A few photographs taken during visits to detention facilities are included to assist in contextualising the drawings. Figure 6.1 is an example of the ID cards that all infants, children and adults were required to wear and show continuously. Children frequently wrote their number before, or instead of, their name on their drawings.

Figure 6.1: ID card for a baby, Christmas Island, 2014

Understanding children's drawings

The literature on the interpretation of children's drawings is informed by a wide range of developmental and theoretical perspectives and priorities. This includes a focus on compositional elements, or representational accuracy, for example of the human figure and body parts (Goodenough, 1926; Malchiodi, 1998; Strommen, 1988; Thomas & Silk, 1990). Other papers focus on interpretation of relationships as represented in the drawings, or on the drawing process itself rather than as a finished product (Einarsdottir, Dockett & Perry, 2009). For more detail see Appendix F.

I acknowledge that the children who produced these drawings might have then told, or would now tell, different stories about their experiences and have different priorities from mine about what they wanted to convey about their life in detention. In the main I will simply describe what the children appear to convey in their words and images, as a way to see and hear the children's evidence and testimony as directly as possible. Just as there is no simple formulaic or consistent way to understand or interpret children themselves, the same is true for their drawings. The approach I have taken is informed by my professional training and experience, as well as my contact with children who are detained after seeking asylum.

The drawings

During my first visit to Woomera IDC with colleagues in 2002, I met with two families and heard their stories in detail. The paper written after that visit (Mares et al., 2002) includes de-identified elements of their stories and other quotes and comments, as well as four drawings. Two of these were made by teenagers while I talked with them and their parents. I was given permission by the adolescents and their parents to include the drawings in the paper.

The paper includes the following excerpt: "The P family have two teenage children and a son aged 3. The father and daughter cried through much of the interview and repeatedly expressed the wish to die. She said: 'All the time I think about how I can kill myself. Life here has no meaning for me, all the time in my mind, over and over, how can I do it? My [younger] brother doesn't know what flowers look like. This is not a life" (Mares et al., 2002, p. 93). The family was detained in a high-security facility in a remote, hot part of Australia, and the compound where they were held was characterised by "harsh areas of dust and stones with no shade, surrounded by two fences of razor wire" (Mares et al., 2002, p. 93). Figure 6.2 is a photograph taken outside Woomera IDC in 2002.

As well as reporting their symptoms (tearfulness day and night, nightmares, sleep disturbance, intrusive images of their father attempting suicide by cutting his wrists), the older child described their mood as "Worst at sunset, when it is dusky – the weather then is like our mental situation" (Mares et al., 2002, p. 93).

Figure 6.2: Woomera IDC Photo taken in 2002

The first drawing (Figure 6.3) was drawn roughly in pen on butcher's paper and is captioned with a comment made while drawing: "All I can see is the wire and us behind it". The drawing and comments present a clear picture of the bleak experience of being detained. The figures behind the wire are reduced to mere scribbles, as if the author could barely be bothered representing them, or that there is a sense of barely existing as people. My memory is of exhaustion and despair communicated in words but also in the child's posture and facial expression. Both teenagers said they were "tired all day with no interest or concentration, experiencing frequent intrusive thoughts of suicide and self-harm". The words "All I can see is the wire and us behind it" can be understood as a reflective statement, emphasising not only the wire but also the family's state of captivity (Mares et al., 2002, pp. 93-94). This statement also seems to include a loss of hope, an inability to see anything beyond the current situation.

The younger of the teenagers was overtly angry as well as depressed. She drew a picture of a weeping bird in a cage (Figure 6.4). I said something like, "Is this how you feel, caged up and sad?" She responded angrily and with emphasis, "This is not how I feel, it is how I am" (Mares et al., 2002, p. 94). The drawing, in which she asserts her lived experience, was included with her permission on the cover of the journal and also in an edited collection of stories by asylum seeker advocates (Mares & Newman, 2007, p. 66).

Figure 6.3: "All I can see is the wire and us behind it"

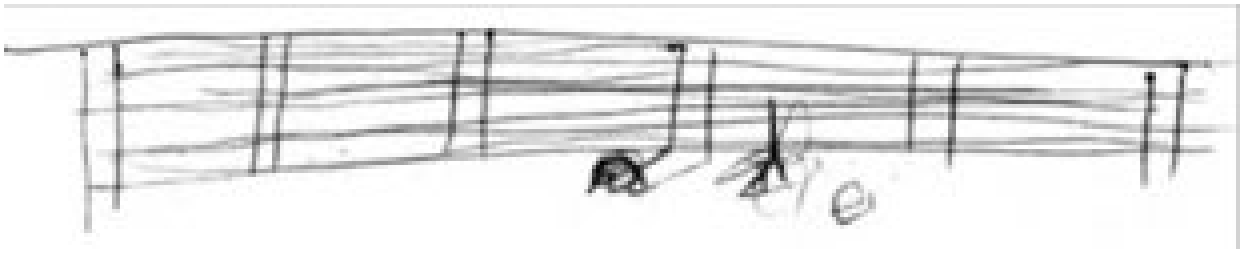


Figure 6.4: "This is not how I feel, it is how I am"

These two images and the words accompanying them convey the physical and psychological experience of detention. The origins and the nature of these images made in consultation with the children are in contrast to the next two drawings from the same paper, which were made by children I did not meet personally.

These two drawings show violence in the camps during protests by detainees, guards in riot gear, water cannons and injured detainees. They also record that children and infants were exposed to and witnessed violence by detention staff. As these drawings were not given to me personally, I have little knowledge of the children or when and why the drawings were made. They were obtained by advocates in contact with families held in Woomera and were

part of a widely distributed cache of images made by children at this time, some of which were included in the 2004 HREOC inquiry report (HREOC, 2004).

The drawing in Figure 6.5 is a brightly coloured and detailed drawing by a nine-year-old. She has included her ID number (blacked out) but not her name on the drawing. The guards in riot gear are prominent, with 'ACM' (the initials of the detention company) marked on them. The water cannon is central, shooting water at and onto a figure lying on the ground with red blood coming from him. A crying mother holds a small baby nearby. Several children watch what is happening. The page is covered in vertical lines, presumably indicating the bars, with the razor wire coiling across the top of the page. The colour and simplicity of the drawing and the graphic detail make it a powerful and emotive representation of events this child had seen. The drawing communicates facts about detention. There are high fences with razor wire and the ground is stony. There are guards with batons raised and a water cannon. People were hurt. It shows what happened, but also who was there, what people did and saw, what children were exposed to. Some of the faces show tears.

This image was also included in a co-authored chapter discussed in the next chapter (Steel, Mares et al., 2004, p. 670).

Figure 6.5: A nine-year-old's experience of life in a detention centre

The final image from this paper (Mares et al., 2002) also represents the riots at Woomera (Figure 6.6). It is drawn by an older child in black pen or pencil and shows guards in riot gear

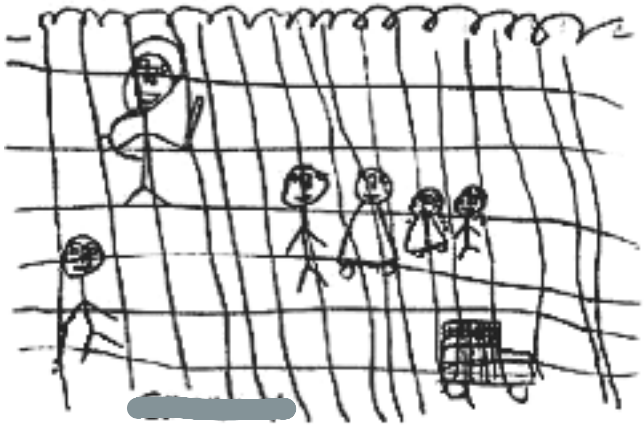
beating a man who is falling down. Behind him detainees protest with a banner demanding freedom and a man stands on the fence amid the razor wire. This is a less naïve drawing than Figure 6.5 but equally powerful. It again records in detail the fact of the fences and razor wire and the actions of guards and detainees. The man standing on the wire may be protesting or threatening to jump. While Woomera IDC was operating, many detainees harmed themselves and attempted suicide by jumping from or onto the razor wire.

Figure 6.6: Drawing by a teenager in Woomera after riots in 2001

A six-year-old child, who I will call SB, was the subject of a paper by clinicians caring for him during his hospitalisations (Zwi et al., 2003). The paper was identified in the scoping review. This child made a number of drawings about his experience. One of these is included in the co-authored book chapter on the ethical and therapeutic issues raised by immigration detention (Steel, Mares et al., 2004, p. 665); this paper is included in full in Chapter 7. This child's black and white drawing (Figure 6.7) again shows the physical and psychological realities of detention; it has a very prominent fence with razor wire covering the page and sad-looking people behind it. A large guard with a baton, who appears to be smiling or speaking, stands at the back, and there is a small vehicle and five figures. Two figures are larger and may be adults, two are small and one is alone. This image and the two above appear to be representations of similar experiences: detention behind fences topped with razor wire, powerful guards in uniform with battons, detained people, including children.

The drawings show the different ways that children at ages five, nine and in their teens represent figures and their experiences.

Figure 6.7: Drawing by SB



Included earlier in this chapter are two papers written with Karen Zwi after visits with the AHRC to the Christmas Island and Darwin detention facilities during 2014. The first paper, primarily about children and families, included eight drawings. The second, which focused on the experience of unaccompanied minors, included their direct quotations and a poem. These drawings and written communications were produced while we and other members of the AHRC team met with detainees in their language groups. The AHRC team provided drawing materials and invited children to draw pictures to tell us about their lives and gave the older children and adults the opportunity to provide written as well as verbal information. The AHRC gave permission to include the children's drawings and words in these two papers (Mares & Zwi, 2015; Zwi & Mares, 2015). Figure 6.8 is a photograph of the outside of one of the APODs where families were held on Christmas Island.

Figure 6.8: Taken outside Lilac Camp APOD for families on Christmas Island, 2014

The next drawing (Figure 6. 9), entitled ‘Sad people lining up and waiting in the rain’, is included in a section of the paper about daily life in the detention camps (Mares & Zwi, 2015, p. 664). The drawing, which has features to suggest it was made by a child aged between six and ten years of age, communicates information which is entirely congruent with what we observed and were told about the physical and practical realities of life in what was designated an APOD. Other authors have confirmed the penal nature of facilities designated as APODs (Essex & Govintharajah, 2017). The climate both on Christmas Island and in Darwin is tropical and therefore the weather was often extremely hot and wet. Several times every day detainees had to line up without shelter for meals, medicines, medical visits, nappies and infant formula. The figures drawn here have sad facial expressions and all but one appears to have their hands clasped, or absent. The figure drawn with more detailed features, arms and clothes appears to be out of the rain and has a more active posture and expression. Because the child’s narrative is missing, we do not know who this figure represents – perhaps a self-portrait, or of an officer. It has been suggested that the absence of body parts, including limbs and facial features, in drawings by children aged over five years old can be indicators of subjective states, such as powerlessness or ineffectuality, and that specific features such as clasping of hands can indicate passivity, or anxiety about forbidden impulses such as anger (Thomas & Silk, 1990, p. 113).

Figure 6.9: “Sad people lining up and waiting in the rain”

The following image (Figure 6.10) was included in Chapter 3 to illustrate the stages of the refugee journey. When read right to left these are: war at home, the boat journey, and detention. As suggested earlier, it also tells more than this. The child has included their name and their boat number and words above each image. The drawing shows changes in the composition of the family over time and also suggests changes in family relationships. In the first image, three figures stand together holding hands, and a fourth is beside them as bombs fall on what looks like an apartment block. During the boat journey there appear to be four figures, now separate amid sea and rain. In detention the bars are prominent; five figures with sad expressions stand alongside each other, arms up but not connected. There are two large and three smaller figures, and the mother is obviously pregnant. The drawing communicates feeling states as well as events but, again, the absence of a detailed narrative from the child limits further interpretation.

Figure 6.10: An 11-year-old's story: (right to left) war at home, fear on the boat, sadness in detention

Another image included in this paper (Figure 6.11) is a reminder that the previous image (Figure 6.10) does not present a complete version of the 'refugee journey'. Immigration detention is a liminal, transitional place, neither inside or outside Australia, not a place of settlement or of refuge. If the drawing in Figure 6.11 is read alongside that in Figure 6.10, it is possible to see the imagined completion of the journey from war, through displacement, flight into detention and then eventual safety. This child has created a picture that compares

the situation of a sad figure, drawn in black and white, with patched clothes, wearing thongs and within a cage (detention) with a happy, coloured image under the word 'Australian'. This shows what appears to be a smiling mother and child, and the child is saying 'sinema', (possibly cinema). The child's boat number has been included but has been obscured. This image can be read both as a representation of the reality of their experience, but also a drawing about injustice and/or a drawing of imagination, perhaps of the future that is or was hoped for.

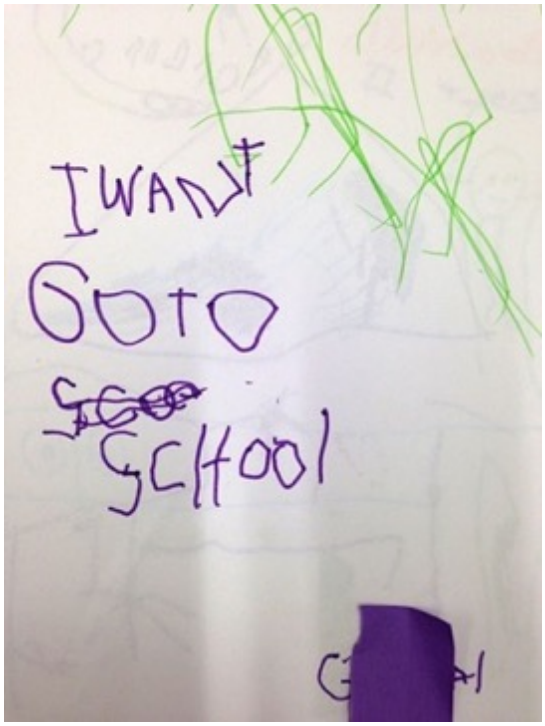
Figure 6.11: A seven-year-old draws the sense of injustice: a happy family outside detention, them-selves locked up

Another image (Figure 6.12) conveys hope, as well as deprivation, and includes just the words "I WANT GO TO SCHOOl" written in a childish hand, with the letters 'SCOO' written above and crossed out. There is green scribble at the top of the page, as if a younger child might also have been using the paper. This image shows some of the child's process and his or her desire to learn and to write and communicate as well as possible. It tells us that schooling is not available in detention. The child's ID number has been obscured.

The paper includes a quote by a 10-year-old that resonates with this and the following images. The child said: "When I see my parents crying, I feel very sad. When I see that you are free, I want to be free as well. When they let me go … to school I was happy, but sad as well … I feel I am here in a zoo, like an animal behind a fence" (Mares & Zwi, 2015, p. 666).

Access to schooling was very limited for children detained on Christmas Island between 2010 and December 2014. For some months a small number of children took turns to attend classes at the local primary school, but this was not sustainable as the number of detained children increased. In 2014 Catholic Education services from Western Australia were contracted to provide 'learning centres' for some detained children, but these remained inadequate to accommodate and teach the numbers of detained school age children (AHRC, 2014, pp. 130-32 & 146-47).

Figure 6.12: A child's plea



Three family drawings (Figures 5.13 to 5.15) are also included in this paper (Mares & Zwi, 2015). They show sad figures behind bars, and seem to have been drawn by children aged five or younger. The first (Figure 6.13) was drawn by a child aged two years and five months. The name and boat number have been obscured. The 'tadpole' figures are consistent with those drawn by many children this age. The drawing in Figure 6.14, by a slightly older child, shows what appear to be two adult and two smaller figures with sad expressions contained in a box with bars. The third, drawn by a five-year-old (Figure 6.15) shows development in the details given to the three sad figures, including tears running down their faces. Despite the figures being detained together, none of the people in these three drawings are touching each other, potentially conveying a sense of isolation as well as sadness.

Figure 6.13: Drawing of the family by a child aged two-and-a-half

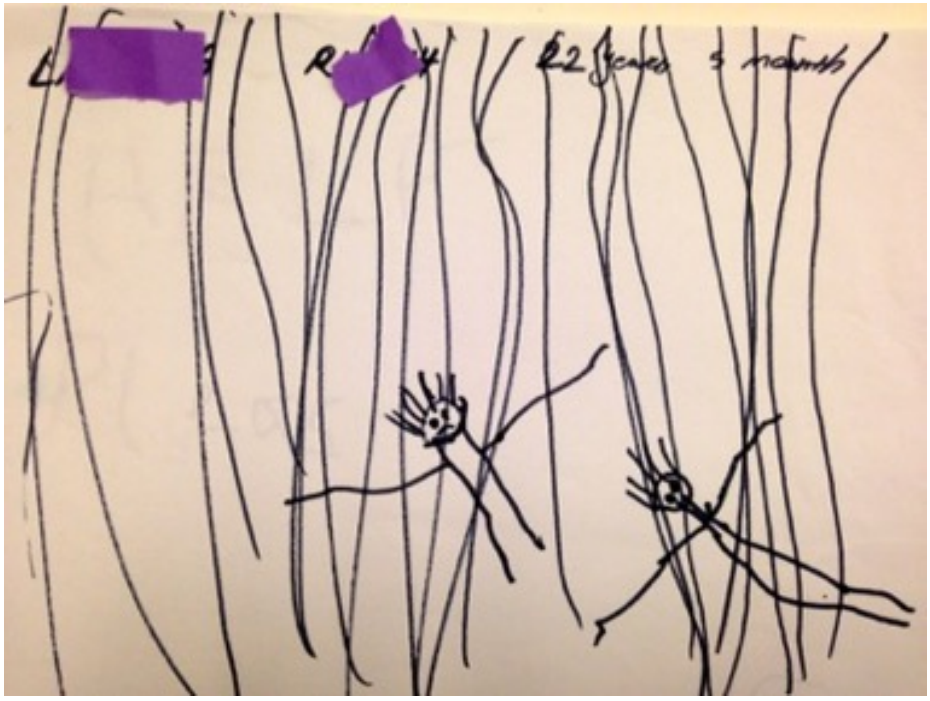
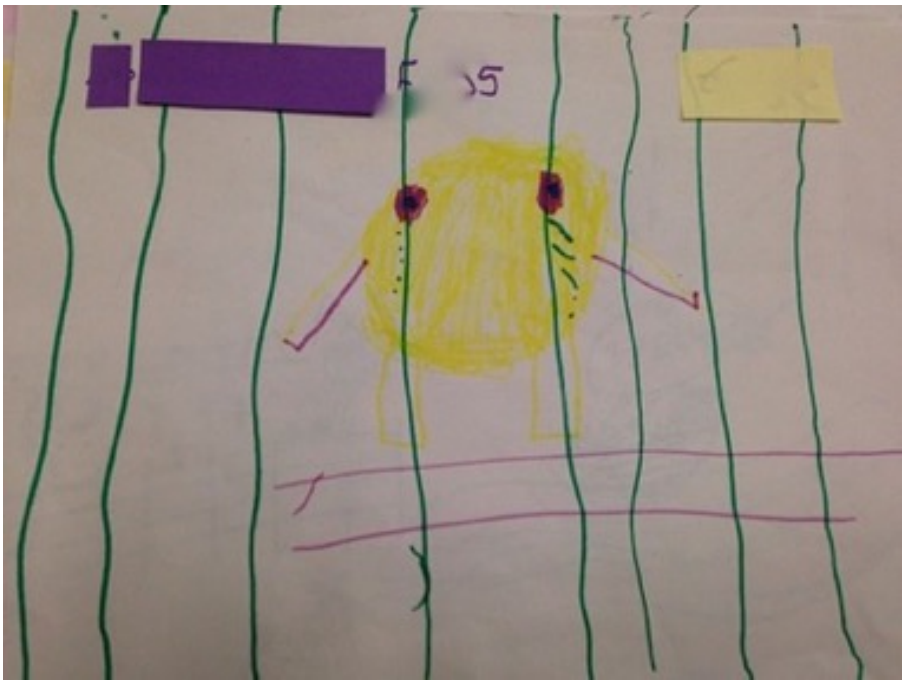


Figure 6.14: A young child's drawing of their family

Figure 6.15: A five-year-old draws their family

The final image in this paper (Figure 6.16) contains elements that are developmentally incongruous, and the age, development and gender of the person who created it is unclear. It may have been drawn by a child with developmental disability or by more than one member of a family. The figure behind bars has a large round yellow head/body, eyes with pupils, and tears, but no nose or mouth, and rudimentary arms and legs coming from the head. Name and ID number have been concealed. The tadpole-like figure with arms coming out of the head suggest a young child, but the detail in the eyes, the careful colouring in and mix of colours used and the solid legs suggest an older child. The different marks indicating of each set of tears could also indicate there were at least two artists. The tears indicate sadness, but the figure has no nose or mouth. The absence of a mouth could be interpreted as an indication of being silenced or impotent (Thomas & Silk, 1990) and is similar to the absence of arms described above but this is speculative. The bars are again prominent.

Figure 6.16***: A crying figure***



The second paper written after visits with the AHRC to Christmas Island facilities was focused on unaccompanied adolescents. It included the children's experience by directly quoting their spoken and written words, including a poem (Zwi & Mares, 2015). These writings are not repeated here but can be accessed in the included paper.

6.2 Conclusion

The included papers provide evidence about the barren physical and intense climatic environment immigration detention centres at Woomera and on Christmas Island. More importantly, these are authoritarian penal institutions, even those facilities located in urban centres or designated as APODs. Imprisonment is associated with dehumanising experiences for adults and children, such as identification by number, a rigid hierarchical power structure, loss of agency and autonomy, and constant reminders of imprisonment and surveillance. These experiences were reported as humiliating, intrusive and intimidating. They represented an additional traumatic burden that directly undermined parenting and contributed to deteriorating mental health in adults and children.

Children were exposed to rioting, protests and violence and had little access to potentially protective experiences such as schooling, or safe places to explore and play. High rates of mental illness in parents and unrelated adults exposed children to despair and self-harm. All

the children who were assessed clinically and 75-100% of the children in studies where quantitative methods were use displayed significant emotional, behavioural and/or developmental symptoms (Mares et.al, 2002; Mares and Zwi, 2015; Zwi and Mares, 2015; Mares, 2016b; Mares & Jureidini, 2004). Parents were unable to adequately provide for or protect their children and, as a consequence of parental mental illness, parenting was further undermined, and children exposed to increased and cumulative adversity and risk.

The drawings and quotations from detained children aged between two-and-a-half years and 17 years are given particular emphasis. They enable the direct inclusion of the children's evidence and experience, what they have seen, what it has felt like for them, and their hopes and fears for the future. These images and words enrich the other sources of evidence provided in the publications.

Each of the papers included above, and the children's experience communicated directly in their words and drawings, provides evidence about the environment of immigration detention and the mental health of those detained, but also raises moral and ethical questions for clinicians and researchers about how to respond to this situation. These questions are examined more specifically in the four papers included in Chapter 7 and in the subsequent discussion.

Chapter 7: Clinical and ethical issues raised by detention of children and families

The previous chapter featured papers about the environment and mental health impacts of immigration detention. The observational and clinical evidence was enriched by inclusion of the drawings and words of detained children. After the first visits to Woomera IDC in 2002, and, as detailed in Paper 1 and Paper 2 (Mares et al., 2002; Mares & Jureidini, 2004) my colleagues and I identified not only the clinical and systemic issues for detained children and families but also realised that psychiatrists and other health professionals have a role in treatment but also advocacy on behalf of vulnerable groups of people.

These papers (Mares et al., 2002; Mares & Jureidini, 2004) anticipate several issues for health professionals working with detained people that became more evident on subsequent visits to detention centres and were explored further in later publications included in this chapter. These issues can be put as questions. What are the ethical issues associated with detaining people in the name of deterrence? How should researchers, psychiatrists and other health professionals respond to Australian's treatment of asylum seekers? Is effective and ethical assessment and intervention possible in this context? What is the place for advocacy and how is it best undertaken? Given the obstacles to research and the consequent limitations of the evidence, how could or should research in this setting be done differently? Finally, what is the impact of undertaking this work? These issues are identified and considered in the following papers and will be returned to in Chapter 8.

7.1 Papers on the professional and ethical implications of the findings

The following four publications focus primarily on the clinical, ethical and professional implications of immigration detention of children and families who seek asylum. There are two co-authored book chapters on the issues for clinicians and researchers (Steel, Mares et al., 2004; Mares & Jureidini, 2012) and an invited review paper that summarises the data that was available at that time about the mental health impacts of detaining children and families, including the process, findings and response to the AHRC inquiries in 2004 and 2014 (Mares, 2016a). The final paper is an invited and co-authored editorial on the role of

psychiatrists in researching and advocating in relation to the mental health of asylum seekers in Australia (Silove & Mares, 2018).

Paper 7

Steel, Z., Mares, S., Newman, L., Blick, B. & Dudley, M. (2004). The politics of asylum and immigration detention: Advocacy, ethics and the professional role of the therapist. In J.P. Wilson & B. Drozdek (Eds.) *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture survivors* (pp. 659-87). New York: Brunner-Routledge.

Although not the first author, I played a significant role in planning, structuring, writing and reviewing this chapter from a book published in 2004. It provides a brief historical and political background, including (then) contemporary quotations from politicians and senior public servants, questioning the evidence that immigration detention had negative mental health consequences. It includes case vignettes, children's drawings and the words of mental health professionals who had experience of working within immigration detention. As the title suggests, the aim was to articulate the dilemmas and provide a framework for clinicians attempting medical and therapeutic work with detained adults and children. This was one of the earliest publications in the local or international literature to specifically articulate and examine the ethical and personal issues faced by professionals working with adults and children in immigration detention.

Zachary Steel took primary responsibility for editing and submission of the chapter but planning and delivery was collaborative. In addition to contributing to the chapter overall, I had primary responsibility for initial drafting and finalising the writing for sections on the challenges of the work for clinicians (pages 661-670 approximately). My contribution can be summarised as 35% of design, 25% of content and 35% of writing and editing. The paper is reproduced with permission.

CHAPTER

25

The Politics of Asylum and Immigration Detention: Advocacy, Ethics, and the Professional Role of the Therapist

ZACHARY STEEL, SARAH MARES, LOUISE NEWMAN, BIJOU BLICK, AND MICHAEL DUDLEY

Increasingly a number of Western democratic countries appear to be turning away from their commitment to universal humanitarian principles. This is particularly evident following the events of September 11 and the associated introduction or attempted introduction of laws substantially infringing the rights and civil liberties of the general citizenry. The neglect of humanitarian principles is seen in the creation of extra-judicial detention zones, such as in the U.S. military prison at Guantanamo Bay, originally used to house Cuban and Haitian refugees, and in the refugee camps established by the Australian government on Manus Island in Papua New Guinea and the Island Republic of Nauru. A withdrawal from internationalism and associated commitment to international law is particularly evident in the United States and

Australia where there is a refusal to ratify or to translate into domestic law international human rights treaties and obligations.

The retreat from the humanitarian enterprise has been most marked in the manifest response to asylum seekers. Policies of deterrence have been variously pursued by the majority of Western democratic countries (Silove, Steel, & Watters, 2000). At the most fundamental level this has involved the implementation of visa and travel restrictions, preventing asylum seekers from making refugee protection claims at or within the border of Western countries. These strategies have been further augmented by stringent departure and transit document inspections with sanctions and fines leveled against companies transporting persons without valid travel documents. In late 2001, the Australian federal government further strengthened border protection initiatives by implementing a naval blockade of northern Australia, interdicting asylum seekers traveling from Indonesia and returning boats, or where this failed, transporting them to the aforementioned detention centers on Manus Island and Nauru. Accompanying legislation excised a number of Australian island territories from the Australian migration zone to ensure that any asylum seekers who managed to reach Australian shores would be unable to trigger Australia's protection obligations under the 1951 Refugee Convention and 1967 Protocol. Although the right of every country to protect the sovereignty of their borders is enshrined in international law, the UN High Commissioner for Refugees (UNHCR) has noted that such measures to restrict the movement of people have not only prevented the movement of illegal and irregular migrants, but have almost certainly obstructed the flight of people who have a genuine fear of persecution (UNHCR, 1997, p. 196).

Despite such strategies some 9 million asylum seekers have requested refugee protection within Western Europe, North America, and Australia over the period 1985 to 2002. The pressure posed by asylum seekers has led to a differentiated response by industrialized countries with the Anglophone countries of the United States, the United Kingdom, and Australia appearing to be at the forefront in the development and implementation of stringent asylum procedures (Silove, Steel, & Watters, 2000). These have variously included: restricted or no permission to work; restricted or no housing support; restricted or no access to welfare support; restricted or no access to health care; restricted or no access to legal services; through implementation of a narrow interpretation of the refugee convention, limited rights of independent judicial review; financial penalties for appealing negative refugee decisions; the issuing of temporary protection visas; and the detention of certain categories of asylum seekers in immigration facilities or state prisons.

The policies of deterrence pursued in response to spontaneous asylum seekers raise important practical and ethical issues that must be addressed by health practitioners. Governments pursuing such policies are in effect manufacturing difficulties and hardships for displaced and war-affected populations with the aim of ensuring that asylum seekers

do not trigger protection obligations incurred as signatories to the Refugee Convention. The consequence of such "get tough on asylum seeker" policies are at least in part health related. The burgeoning research among refugee and postconflict populations has repeatedly documented ongoing risk to mental health problems, particularly depression and posttraumatic stress reactions (Cardozo, Vergara, Agani, & Gotway, 2000; de Jong, Mulhern, Ford, van der Kam, & Kleber, 2000; de Jong, Komproe, van Ommeren, El Masri, Araya, & Khaled, 2001; Modvig, Pagaduan-Lopez, Rodenburg, Salud, & Cabigon, 2000; Mollica et al., 1993, 1999). Research undertaken in Australia, one of the lead countries in the implementation of policies to deter asylum seekers, has demonstrated that postmigration stressors, most of them deliberately manufactured as part of the deterrence regime, are directly associated with deteriorating mental health (Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997; Steel & Silove, 2000; Steel, Silove, Bird, McGorry, & Mohan, 1999).

The ethical problems arising from this policy approach are particularly acute with regard to use of indefinite nonreviewable mandatory detention of asylum seekers. The remainder of this chapter will focus on the professional, clinical, and ethical issues associated with the detention of asylum seekers as they have emerged within the Australian context.

DENYING THE SELF-EVIDENT: THE MENTAL HEALTH COSTS OF IMMIGRATION DETENTION IN AUSTRALIA

> The conditions — the environment — is particularly harsh. It's a moon scape. It's dust and rubble. There's no grass inside the compound. There's sparse brush on the red desert outside the compound. There's one tree in the main compound, double palisade fencing around the entire perimeter with razor wire top and bottom. There are different compounds divided up by fences. Quite often there are barriers between the compounds so that detainees can't see, or hear, one another speaking or see each other. It's particularly hot in summer. The main compound: there was a temperature of 61 degree Celsius [142° Fahrenheit] recorded the summer that I was there and it's bitterly cold at night in winter.
>
> Mark Huxstep, former nurse, Woomera Immigration Reception and Processing Centre. Evidence provided to Human Rights and Equal Opportunity, Public Hearing, National Inquiry into Children in Immigration Detention, August 5, 2002

In 1992 the Australian federal fovernment passed legislation enforcing a policy requiring the mandatory detention of all persons arriving in Australia without valid entry documents. Since then the vast majority of unauthorized asylum seekers and accompanying children have been detained for the full duration of the refugee determination process or until removal procedures have been enforced. Many asylum seekers are

held in detention for indefinite and often considerable periods of time. A report into the conditions of detention in 1998 (Human Rights & Equal Opportunity Commission, 1998) identified over 80 detainees who had been held in detention between 2 and 5 years. A case is cited of two Cambodian brothers aged 16 and 19 years who were detained for 5 and a half years before being released without a final decision regarding their status being made. The most recent departmental figures (April 12, 2002) indicates that there were 346 individuals held for between 12 to 18 months and 256 individuals held in excess of 18 months.

Throughout the 12-year history of this policy, the detention centers have been plagued by controversy. Riots, damage to property, hunger strikes, acts of self-harm, and attempted suicides have gained national and international media attention. Statistics obtained under freedom of information legislation revealed that during an 8-month period from March 2001 to October 2001, 264 incidents of self-harm requiring medical attention came to the attention of authorities in a population comprising approximately 2,000 persons. Using these figures, Dudley (2003) estimates that the annual self-harm rates for men and women held in detention are 41 and 26 times the male and female national suicide attempt and self-harm rates respectively.

The policy of mandatory detention and the operation of the detention facilities in Australia has attracted widespread criticism from national and international human rights bodies and organizations such as the United Nations High Commissioner for Refugees (1997), the United Nations Commissioner on Human Rights (OHCHR, 2002), UNICEF (2002), the Australian Human Rights and Equal Opportunity Commission (HREOC, 1998), the Australian Commonwealth Ombudsman (Commonwealth Ombudsman, 2001), Amnesty International (2002), Human Rights Watch (2002) and the U.S. Committee for Refugees (2002). A key issue raised to the Australian government from these bodies has been the poor mental state of detainees and particularly children held for protracted periods.

Annie Sparrow, a senior registrar in pediatrics who worked in one of the remote detention centers during 2001 and 2002, stated that:

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

> fear and anxiety. (Professional Alliance for the Health of Asylum Seekers and Their Children, 2002)

Similar concerns have been raised by key members of the immigration detention advisory group established by the Australian federal government to provide advice on the appropriateness and adequacy of detention services, accommodation and facilities. On May 8, 2002, Paris Aristotle, a member of IDAG and a mental health professional, told a media program regarding the Woomera Detention Centre in South Australia that:

> a culture of self-harm and the extent to which depression and anxiety are dominant within the population at the detention centre has now really become endemic and had reached quite a staggering degree. And what was obvious to us was that no matter how hard people were going to try, … it's now reached a point where, I think, it's actually impossible for them to prevent harm occurring within the centre at Woomera, and particularly in the case of children. (Lateline, 2002b)

On another occasion Harry Minas, a psychiatrist sitting on the same committee, stated that:

> Prolonged detention is psychologically harmful to children, particularly when the prolonged detention is in circumstances such as those at Woomera. Children are exposed to all kinds of behavior, all kinds of problems. In Woomera at various times there have been episodes of self harm, some of which have been witnessed by children, there have been some episodes of violence again witnessed by children. But I think also being in prolonged detention can seriously distort family relationships so that the parents of those children don't have the opportunity to look after them properly. (Lateline, 2002a)

In addition to these anecdotal reports, systematic evidence documenting severe mental health conditions among long-term detainees has emerged from a number of health surveys undertaken within the detention environment. The Victorian Foundation for Survivors of Torture (Paris Aristotle, personal communication, November 16, 2001) carried out a file audit of clinical assessments undertaken with 46 Cambodian asylum seekers, representing the majority of Cambodians held in Villawood and Port Hedland detention centers from late 1993 to mid-1994. At the time of interview a significant number had been detained in excess of 2 years. Clinical interviews indicated that the majority of the Cambodians had histories of trauma or multiple trauma, with 62% meeting diagnostic criteria for posttraumatic stress disorder and all displaying clinically significant symptoms of depression. The clinicians undertaking this survey concluded that the major factor that appeared to be contributing to the severity of the clinical conditions encountered was the duration of detention.

Maritza Thompson and colleagues (1998) reported the findings of a survey of 25 detained Tamil asylum seekers held at Maribyrnong Detention Centre in Melbourne during 1997 and 1998, using the Harvard Trauma Questionnaire (Mollica et al., 1992) and the Hopkins Symptom Checklist (Mollica, Wyshak, de Marneffe, Khuon, & Lavelle, 1987). Detainees exhibited a significantly higher level of depression, posttraumatic stress, anxiety, panic, and physical symptoms, compared to 62 compatriot Tamil asylum seekers residing in the community. A third study undertaken by Sultan and O'Sullivan (2001) reported that 32 of 33 detainees surveyed at an immigration detention center in Sydney displayed symptoms consistent with a major depressive illness, with 16 persons showing severe emotional distress. As with the Cambodian study the authors documented a significant deterioration in the mental health of detainees as the length of detention increased.

THE CASE OF SHAYAN BADRAIE

The plight of asylum seekers in detention was vividly brought to the attention of the broader Australian and medical community in Australia when the investigative journalist Debbie Whitmont screened a video secretly filmed in one of the detention centers on the Four Corners program in August 2001. The video contained footage of a 7-year-old boy, Shayan Badraie, who had been held in detention for 14 months. The footage showed a boy who was cradled in his mother's arms, he was mute, refusing to eat and was too weak to walk. He was being wheeled about the detention center by his parents in a wheel barrow. Shayan was 6-years-old when he first presented to a children's hospital emergency department having stopped eating and talking. During an 11 month period in a remote detention center Shayan had witnessed acute distress among detainees, riots, and self-harming behaviors, including attempted self-immolation. He had been distressed since this time with chronic sleep disturbance, nightmares, and bed-wetting. After transfer to an urban detention center he witnessed a man attempting suicide by wrist cutting and had become withdrawn and mute. Shayan was found to be dehydrated and underweight and was admitted for rehydration. He began talking and eating while in the hospital. He described nightmares about suicidal behavior and ongoing features of posttraumatic stress disorder. He was fixatedly drawing the same picture over and over again, consisting of a man with a line on his wrist and drops of blood coming down. He and his father, stepmother, and sister were depicted behind wire with tears flowing down from their eyes (see Figure 25.1).

On discharge the treating clinicians recommended that Shayan and his family be removed from the physically restraining environment of the detention center and advised that if Shayan remained in detention he would likely relapse. This advice was ignored and as predicted Shayan re-presented 6 days later, refusing to eat or drink. For the hospital staff

Fig. 25.1 Drawing by Shayan Badraie

this triggered a discussion with the detention center provider, Australasian Correctional Management, the Department of Immigration, and the detention center medical services. Hospital staff argued that returning Shayan to detention could only result in a repeat of this situation, and that this was clearly against his best interests. The children's hospital saw itself as having a duty of care to protect Shayan from retraumatization, and this put them in direct conflict with the detention center and the Department of Immigration. After 8 weeks, and significant clinical improvement, he was discharged to the detention center as no resolution about community release had emerged, despite appeals to the responsible minister. Over the following month Shayan repeatedly re-presented to the emergency department with food refusal, dehydration, and weight loss. It was only after the public airing of this case by the Four Corners program that the Minister of Immigration decided to act, removing Shayan from his family and placing him in foster care, against the advice of the hospital. Shayan became extremely distressed at the separation from his family, expressed suicidal ideation, and had ongoing symptoms of posttraumatic stress disorder. The placement remained tenuous and Shayan's mother, sister, and subsequently his father were granted visas and released from detention. He continues to receive trauma counseling.

WHEN MEDICAL ADVICE IS NOT APPRECIATED

The case of Shayan Badraie raised complex clinical and ethical dilemmas for all clinicians involved. A key concern was the need to protect the child from harm and the immediate opposition this set up with the Department of Immigration and the policy of mandatory

detention. Clinicians raised their concerns that "treatment" became meaningless or was undermined when the child was returned to the same environment linked to his trauma and ongoing symptoms. For some this signified a fundamental erosion of the clinical role and highlighted issues of clinical decision-making. Clinicians essentially became advocates for the rights of the child for protection and care within a highly politicized context, raising questions regarding the boundaries of the clinical role.

This case sent shock waves throughout peak medical and allied health organizations in Australia. At no time in recent Australian history had the extreme mental suffering of a child been so vividly juxtaposed against a governmental response of indifference. In responding to the Four Corners revelations, the Minister for Immigration, who persistently referred to Shayan as "it," suggested, in contrast to the findings of all the treating clinicians, that his mental condition was due solely to premigration experiences or because he was being cared for by a stepmother.

Shortly following the public airing of the Shayan story, the Royal Australasian College of Physicians (RACP), and Royal Australian and New Zealand College of Psychiatrists (RANZCP), issued a press statement expressing their concern for the welfare of children held in detention and called on the government to undertake an independent, expert review of the impact of detention on children at the earliest possible opportunity, a view endorsed by the president of the Australian Medical Association, Dr. Kerryn Phelps. The lack of an appropriate governmental response to these concerns led to the development of the Professional Alliance for the Health of Asylum Seekers and Their Children. The alliance brought together all medical colleges and guild organizations across Australia as well as other allied health organizations comprising over 50,000 doctors and health professionals. This represented the single largest alliance of health professionals formed on a social issue in Australian history. In May 2002, the alliance submitted a comprehensive review of the best available evidence about the effects of detention on the health and well-being of children and adults (Professional Alliance for the Health of Asylum Seekers and Their Children, 2002), calling for the immediate release of children and their primary caregivers from detention and concluding that "Current practices of detention of infants and children are having immediate effects on their development and their psychological and emotional health which are likely to extend to the longer term."

Nevertheless, despite the expert health opinion reflected in the health alliance statements and submissions; the concerns raised about mental health by independent investigations (Commonwealth Ombudsman, 2001; HREOC, 1998; OHCHR, 2002; UNHCR, 1997); the body of testimonial evidence provided by health staff in direct contact with detainees; and the research evidence reviewed above, a representative of the Department of Immigration stated in April 2003 that:

> While the Department is aware that some detainees may experience difficulties in immigration detention, it is not aware of any independent, scientifically rigorous Australian or comparable overseas data or research to support claims that mental illness is endemic among detainees held in immigration detention.

And concluded: "Unfortunately mental health is an area that attracts a number of allegations. Without verification, these remain no more than hearsay" (Mason, 2003, p. 5).

In response key members of the aforementioned health alliance released the findings of research conducted with 10 families comprising 14 adults and 20 children held in a detention center for over 2 years (Steel, 2003). The study was based on a near complete sample of families from the same ethnic group held in a single detention facility in remote Australia. Structured psychiatric telephone interviews were administered to assess lifetime and current psychiatric morbidity. Findings indicated that exposure to trauma, including witnessing riots, assaults, and serious self-harm attempts was routine within the detention environment. All adults and the majority of children reported being regularly distressed by memories, intrusive thoughts, and nightmares about traumatic experiences that had occurred in detention. The results from the structured diagnostic interviews indicated that all adults and children met diagnostic criteria for at least one psychiatric illness with the majority of adults (12/14) and children (16/20) meeting criteria for more than one psychiatric disorder. The most commonly diagnosed conditions were major depression and posttraumatic stress disorder, although high rates of separation anxiety disorder, enuresis, and oppositional defiant disorder were identified among the children. Comparison with the lifetime and current diagnoses indicated a threefold and tenfold increase in psychopathology among adults and children, respectively, subsequent to detention. The official response from the Minister for Immigration was to dismiss the findings of this study out of hand:

> The *Study of Asylum Seekers in Remote Detention Centres* by University of New South Wales researchers has received wide yet unquestioning media coverage, but it is seriously flawed. It is apparent that it is based on preconceived ideas of the researchers who have been advocates of the dismantling of mandatory detention and who followed a particular line of questioning and reasoning to ensure a result satisfactory to themselves. (Ruddock, 2003)

Another strategy used in the Australian context to minimize issues related to mental illness among detainees has been to reinterpret the definition of mental illness excluding depression.

> *Reporter* (SBS, Insight Program): The World Health Organisation, the Royal Australian New Zealand College of Psychiatry, the Federal Health Ministry says that depression is a mental illness. Does it

> concern you that the Department is not classifying depression amongst detainees as a mental illness when those figures are asked for?
>
> *Philip Ruddock* (Minister for Immigration): Not really. I think I mean as long as you can deal with the various conditions and describe them — as I say, depression is quite significant in the Australian community and people are treated for it and I'm not sure that everybody would regard depression as being a mental illness. Now, you, look you may have some colleges and World Health Organisations that will describe it that way, but I'm not sure it would be seen that way more broadly in the Australian community. (Insight Program, 2003)

This exchange and the departmental decision not to classify depression as a mental illness when reporting on the health of detainees are deliberate and self-evident attempts to prevent information regarding the extent of mental illness within detention from being known.

"Moving the (scientific) goalposts" and forays by the minister into areas beyond his expertise are indications that "science" and "evidence" are terms that have become overtly politicized in this context. These statements are also in contradiction with major health initiatives of other arms of government (Dudley, 2003) and demonstrate the extent to which those responsible for the implementation and management of mandatory indefinite detention will go to hide the suffering of those under its care. However, the systematic attempt on the part of the Australian federal government, to minimize, trivialize, and deny the alleged mental health harms associated with protracted immigration detention might be necessary to maintain the legality of mandatory detention. The putative reasons advanced for the use of mandatory detention are essentially administrative, to ensure that individuals are available for processing and removal from Australia, should that become necessary or possible. Officially detention is not punitive, and if it was shown to be punitive, the practice would likely be unlawful under Australian Constitutional Law. Nevertheless, the Australian government does accept that it has a high level of duty of care to detained asylum seekers and argues that it meets its duty of care obligations to psychologically affected detainees by providing access to mental health care (Ruddock, 2002).

CAUGHT IN THE MIDDLE: CLINICIANS CARING AND ADVOCATING FOR DETAINEES

> A therapeutic process of any client is long term, developing a relationship, getting to know the person's story, getting to know what's happening with that person and then making appropriate treatment recommendations, etcetera. As I said, I think and I believe that I did a good job in Woomera while I was there. I have to believe that for my own well being but I also have to acknowledge, that I was working in a no win environment because I couldn't change the environment.

> No matter how much I worked with the clients, I couldn't change the cause of the behaviour, the course of their stress, it's like having a patient coming into the hospital with a nail through the hand and you are giving them Pethidine injections for pain but you don't remove the nail. That's exactly what is happening in Woomera. You've got people down there with nails through their hands, we're holding them, we're not treating the cause. So, the trauma, the torture, the infection is growing. We are not treating it, we're just containing it. Eventually when those people return to their homelands, if they don't get temporary visas, they are going to carry that with them.
>
> Harold Bilboe, former psychologist, Woomera Immigration Reception and Processing Centre. Evidence provided at Human Rights and Equal Opportunity Public Hearing into Children in Detention, July 16, 2002

Clinicians working with detentees are in contact with severely distressed and traumatized children and adults, whose trauma is in no small part due to their indefinite detention under Australian law. Initial optimism on the part of clinicians and a belief in being able to make a difference is replaced over time by a sense of powerlessness, anger, and guilt akin to that experienced by detainees. This is not simply vicarious traumatization or empathy for their plight. Rather, it arises as a consequence of engaging with and advocating against the legal and political framework that makes up current immigration law in Australia, in circumstances where clinically based recommendations are ignored, adequate access to services is denied, and detention, in its various forms, continues.

Empathy and Vicarious Traumatization

Vicarious traumatization is a term used to describe the effect on health workers and other professionals of exposure to the stories of traumatized patients (McCann, 1990). This occurs in many contexts and is recognized as a consequence of clinical work with survivors of torture and trauma. The impact can be due to the severity or volume of the traumatic accounts and occurs in large part because of the therapist's empathy with and concern for the person recounting the story. In making a clinical assessment the therapist aims to listen and empathize, to understand the experience behind the words. This exposes him or her to the experience and the feelings of the adult or child even if distress is indirectly expressed. Sometimes the poignancy of the actual words also carries great weight. A 13-year-old girl in detention said to one of us (SM) "My brother (aged 3 years), doesn't know what flowers look like. What has he done that is so wrong?" The family had been in a remote detention center since the boy was an infant. Later she said, "I feel worst in the evenings when the sky is dusky, like my mood it gets darker. I have no life here. I wish to be dead."

When a traumatic story is told by a child, either in words, or drawings, or enacted in play, the impact can be particularly intense. A

child can make great efforts to draw his or her "best picture," carefully coloring it in. Great distress is conveyed in the incongruity of the simple colored drawing and the horror of the content. Figure 25.2 is a picture drawn by a 9-year-old girl after she witnesses riots.

Usually the trauma encountered by torture and trauma survivors has occurred in the past. The clinician is therefore able to use the relative safety of current circumstances as part of containing the patient's distress and beginning a process of working through and managing the impact of past abuses. In work with traumatized children, the parents, school, and community can be mobilized as resources to support recovery. Asylum seekers held in detention have not only experienced past trauma, abuse, and loss, but are living in a situation of entrapment, faced with constant uncertainty about their future safety. Significantly, all detainees, including children, report ongoing traumatic experiences within immigration detention. The events and the trauma is not past, but present, and extends indefinitely into the future. The clinician hears the stories and is unable to act protectively or therapeutically.

All the children interviewed by us in remote detention centers, amounting to in excess of 50 children, have witnessed repeated acts of self-harm by adults, including cutting, attempted hangings, self-poisoning, and jumping onto razor wire. Many children had also harmed themselves and were troubled by intrusive thoughts of suicide or images of self-harm and violence. The therapist is confronted with terrible stories of distress and trauma about current, ongoing events. There is a reversal of what is taken for granted about parenting and child protection anywhere else in Australia.

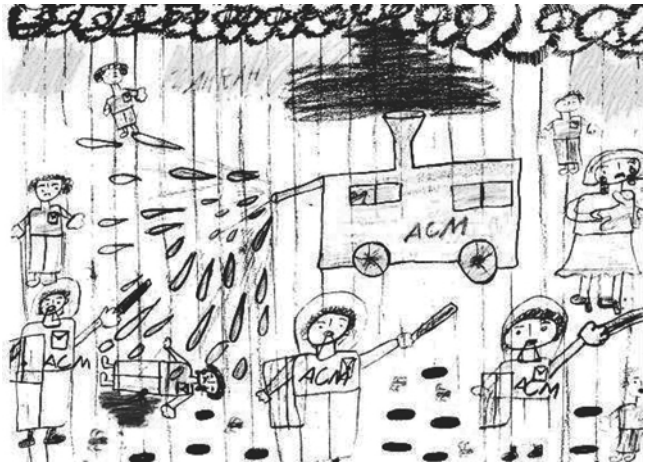


Fig. 25.2 Drawing by 9-Year-Old Girl Following Riots in Detention

In this world of "noncitizens," children believe they carry responsibility for their parents' and siblings' safety and for sexual assault. Infants remain in circumstances of high risk. Parents are incapacitated by guilt and grief as they witness the impact of events upon their children. Recommendations by child protection workers are ignored, as are those by clinicians (Layton, 2003). The clinician can do little but conclude that the setting is a major source of the children's distress and contributes significantly to the parents' inability to adequately protect and nurture their children. Assessments to this effect arise out of clinical observation and experience but are politicized by their inherent conflict with immigration policy. Recommendations that the child and family cannot be adequately treated or cared for in detention have almost universally been ignored. The individual clinician confronted with such devastating outcomes, powerless to act, experiences more than vicarious traumatization as they experience the ongoing trauma of the asylum seeker, they are directly exposed to ongoing trauma.

Naivety and Politicization

Clinicians are not usually trained in politics or sociology. They operate professionally within a system where their expertise is acknowledged and remunerated. They are used to listening and being listened to. They regularly advocate, with effect, for their patients at individual and policy levels. The patients and families they see, whatever their level of disability or disadvantage, are citizens of their own country. They are operating within the "social contract" conferred by citizenship.

In early 2002 a number of us (SM, MD) visited remote detention facilities in south Australia. We went at the request of lawyers representing families whose initial claims for refugee status had been refused and who were psychologically distressed. The aim of our visit was twofold: first to undertake medico-legal assessments that could, if appropriate, be used to support individual families' legal applications, to enable them to live in the community while their asylum claims were processed, and second, to recommend access to mental health treatment for those families. Adults and children were introduced to us by number not name. In small ways we were intimidated and bullied by detention center officers. We saw the harsh and pitiless environment within which children and young adults wandered aimlessly in the sun without hats or shoes. We visited the air conditioned, clean toilet for detention and immigration staff and also saw the dusty, blood-spattered filthy toilets available for detainees. More than this, we heard and felt the despair of the adults and children interviewed. We were motivated to help. We wrote reports and papers and made recommendations. We believed, and so did the people we spoke to, that we could make a difference, that our recommendations would be acted on and that as medical specialists, our words would count.

When we enter the world of detention, despite physically remaining on what appears to be Australian soil, we cross a border that puts us and the adults and children we talk to outside of Australia's legal and political system. We enter a zone where usual conceptions of human rights and obligations to others do not apply. Asylum seekers in immigration detention are officially "unauthorized noncitizens." In a letter to one of us (SM, Phillip Ruddock, personal communication, April 28, 2003), the Minister for Immigration wrote: "the state has the sovereign right to determine which non-citizens can enter the country, those that can remain, and the conditions under which any may be removed. … While deterrence is not a primary purpose of detention, it is an important incidental factor."

The unauthorised noncitizen is not just "them" or "other" by virtue of their statelessness, their nationality, their cultural and religious affiliation, but most importantly by virtue of their "noncitizenship." Aspects of difference or "otherness" have been used to politicize the national debate and "dehumanize" the public image of these vulnerable individuals. At an administrative level, the naive and well-intentioned clinician encounters a system within which not only those they advocate for, but they themselves have no currency and little power. The role of doctor and clinical advocate is altered by "crossing over" into the jurisdiction of immigration law. The social contract, as we usually experience it, does not operate here. As a consequence, our words have no power. At a legislative level in Australia, immigration law overrules federal and state health and child protection legislation. This takes time to understand for the naive clinician who embarks on the process of advocacy for this group with an expectation of making a difference and with little awareness of the obstacles to be encountered. This is echoed at a service level. Some state governments have signed a Memorandum of Understanding with the federal government concerning the health and welfare of detainees. The implications of this for children in immigration detention and state child protection services (in this case in south Australia) are discussed in detail by Layton (2003), who writes:

> Most importantly the Memorandum of Understanding does not recognise the serious systemic abuse of children in detention and that the most serious abuse does not come from individuals, but arises from the circumstances of detention itself. … The State government is being placed in an impossible legal and moral position." (Ch. 22, p. 14)

COMPROMISING CLINICAL CARE AND THE INTEGRITY OF THE CLINICIAN

> A doctor [sic health professional] must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental role is to alleviate

> distress of his or her fellow men, and no motive, whether personal, collective or political, shall prevail against this higher purpose.
>
> The Declaration of Tokyo, 1975 (29th World Medical Association)

Health professionals engage with the detention regime, either on the outside as consultants, advocates, or critics, or on the inside as health staff employees. Those employed on the inside face particular threats to their clinical integrity. In earlier manifestations of immigration detention, such as in the closed refugee camps of Hong Kong in the 1980s and early 1990s, health care services were provided by the Red Cross, or other NGOs and were administratively independent from the management of the detention centers. This enabled health staff to be clearly delineated from those responsible for the security and daily operational management of the centers. The psychological importance of this distinction for the health professional and for the detainees cannot be overstated. Independent health staff can be seen as confidantes and advocates who can sympathize and identify with the plight of detainees and speak out on their behalf.

In contrast, in Australia, health and mental health professionals are employed by the detention center provider, currently Australasian Correctional Management, a subsidiary of the U.S. company Wackenhut Corrections Corporation. It is fanciful to believe that incarcerated asylum seekers can reconcile the anomaly that the organization responsible for overseeing their incarceration and thus their mental and psychological distress is also responsible for providing a service that aims to treat their mental health needs. The despondency, anger, and feelings of injustice of detained asylum seekers is palpable and increases as the period of detention continues. This anger is directed at all staff associated with the system that holds them against their will, and it is unlikely that health staff will be immune, especially as it becomes apparent to detainees that health professionals are unable to resolve the main threat to their mental health (i.e., continued incarceration). This is only compounded by the fact that Australasian Correctional Management has required health staff to wear a uniform that is virtually indistinguishable from the general uniforms of other detention center officers.

Health care practitioners are caught in a highly charged political environment, regardless of their own personal views on the matter. The culture of security, coercive management, and violence existing in Australian detention centers has created a gulf of misunderstanding, mistrust, and resentment between detainees and staff. Health staff are also not immune from such a culture. A majority of detainees we have spoken to have stated their belief that health staff have a promanagement and antidetainee bias, with complaints that all health conditions are treated with general advice to drink more water or by the administration of paracetamol and sedatives. Whether or not such claims are accurate is immaterial, as the mere perception that health

staff are working in the interest of the detention center provider and not in the interests of the detainees is problematic and highlights the major difficulties that face clinicians in these settings. Moreover, regardless of the personal commitment and competencies of an individual health care practitioner, the provision of care is often compromised by the structure of the detention centers. This is well illustrated in the following testimony provided by Mark Huxstep, a former nurse at the Woomera Immigration Reception and Processing Centre, in a statement to Human Rights and Equal Opportunity Public Hearing into Children in Detention on August 5, 2002:

> There was a child who presented to the medical centre and it just so happened that her mother was a qualified doctor in her country of origin, and the child had a painful ear, so the child was given a simple pain killer that evening and referred to the doctor the next morning, who diagnosed an ear infection and put the child on regular pain killers and antibiotics. It was a liquid antibiotic that had to be refrigerated. The detainees aren't allowed to take medications back to their rooms for fear that they will overdose or collect them or whatever the rationale, and so therefore they had to come to the medical centre four times a day to get their medications. That meant coming every six hours with a small child with a sore ear who was crying in the middle of winter at night time, waiting for two hours in a queue at the gate in the freezing cold and it just happened to rain one night, and the mother was terribly distraught. She said, "I'm bringing a sick child to stand in a queue in the cold and the rain for two hours to get treatment," and I had no answer because it was true.

Julie's Story

Julie was pregnant at the time she and her husband fled Iran due to fear of persecution. After a traumatic journey by boat, they arrived in Australia and were held in detention. Julie was transferred to a hospital to give birth to her child, Nadi, but according to her testimony was distressed by the fact that detention center guards were present in the delivery room throughout her labor. Julie's husband was not allowed to attend during the delivery and did not see his wife and child until 5 days after the birth. Julie rejoined her husband in the detention center, but experienced ongoing gynecological problems relating to the birth. She became depressed and anxious. Repeated presentation to the health care staff at the detention center did not result in any effective treatment for these problems. Concerns about Julie's and Nadi's health prompted visitors to the detention center to present Nadi as a child at risk to the state child protection agency. In February 2002 the responsible department assessed the family and found that:

> The information obtained from Julie and her husband regarding her physical and mental health contrasted significantly with that obtained

> from the medical clinic staff at the detention centre. The clinic staff reported that Julie was not withdrawn in any way, had never at any stage been depressed and had bonded well with baby.

In contrast Julie and her husband stated that "she has had a poor appetite for at least six months, is not eating much and feels depressed. She cries every day, sometimes three or four times. Her weight has gone down from about 51 to 45 kg since having the baby." The report concluded that "From her history it is likely that Julie is depressed and has been so for about nine or ten months. It is possible, and could readily be checked up, that she has a gynaecological infection. … Nadi is exposed to significant risk resulting from her mother's depression." The report made three clear recommendations:

1. release of the whole family into the community pending the processing of their documentation;
2. referral of Julie and Nadi to a community baby clinic;
3. urgent referral of Julie to a gynaecologist and a psychiatrist in the community.

These recommendations were not acted upon and Julie's condition continued to deteriorate despite further representations and requests for treatment to the medical staff at the detention center. Two further interventions by the state child protection agency were made stressing the need to act on earlier recommendations.

In crisis, Julie's husband contacted visitors to the detention center who organized for two independent medical practitioners to visit Julie. On arrival these doctors were informed that they were unable to examine Julie without obtaining formal permission from the Department of Immigration. After considerable negotiation, permission to visit Julie informally was obtained, and the Department of Immigration agreed to facilitate contact with her treating physician. However, the primary care physician employed by the detention center was advised not to speak to the outside doctors by the private detention center provider. It was possible to speak to the clinic nurses in the presence of the detention center manager, who stated that Julie had been treated for the past few weeks with sedation but had commenced an antidepressant 2 days previously. They did not know if Julie was taking adequate fluids or eating, as they could not monitor this in the detention center. Julie herself arrived in a wheelchair. She presented as severely depressed, emaciated, and appeared acutely unwell, with obvious signs of sepsis, dehydration, sedation, and altered affect. A letter recommending urgent hospitalization was written but ignored.

A subsequent formal visit by independent paediatric and psychiatrist specialists was organized 3 days later through Julie's lawyers. Assessment indicated that Julie had a combination of major depression, physical compromise, and infection, which was potentially life threatening and

required urgent hospitalization along with her baby, Nadi. Julie was admitted to a local hospital that evening. Her acute medical condition was treated and she was transferred to an inpatient psychiatric unit. After further representations and media intervention, her baby, Nadi, joined her several days later. Julie and Nadi were subsequently transferred to an acute adult psychiatric unit for treatment of severe postnatal depression, where she was continuously guarded by two officers from the detention center. Julie could not be moved to an appropriate mother-baby facility due to the fact that the detention center officers did not have appropriate child protection clearance for such a transfer, and permission could not be obtained from the detention provider to have her moved without the officers. Despite this Julie and Nadi both showed substantial clinical improvement while in the hospital. Julie's treating psychiatrists felt that they could not in good conscience release her back into detention as this retraumatization would be potentially life-threatening to Julie and possibly Nadi. This put them in direct conflict with the detention center and the Department of Immigration, and delayed discharge. Despite representations made by a wide variety of agencies, an impasse remained. Julie and Nadi remained in the hospital for over 5 months until she was eventually granted leave by the Minister for Immigration to remain in Australia, possibly reflecting a compromise solution to the impasse between hospital staff and the Department of Immigration.

This case highlights a number of complexities involved in the provision of health care to immigration detainees. The detention environment in this case did not allow health professionals employed by the private detention operator to adequately discharge their duty of care. This is clearly indicated by the discrepancy between the findings of the detention clinic health staff and the subsequent six physicians and specialists who assessed Julie and her baby. It was extremely difficult for all of those involved on the outside to establish a clear line of responsibility between the Department of Immigration and the detention center operator for the welfare of Julie (for example, the department gave permission for the doctor employed by the detention center operator to speak to independent medical practitioners but the detention operator did not). The inability of other lead agencies involved in the welfare of families, such as the child protection agency and the hospital, to have their treatment recommendations acted upon was undermined. The fact that detention guards who regularly deal with children (including unaccompanied minors in detention) do not require the same child protection clearance as other workers in the community is another example of the different standards of care for immigration detainees compared with the general community. The conflict of interest between the Department of Immigration and the detention center operator's charter to detain people and their responsibility to provide humane and appropriate care is also a primary reason for the failure of care highlighted in this case.

More direct threats to the clinical integrity of health care practitioner arise in respect to the management of detainees engaging in self-harm, suicide attempts, or hunger strikes. Australasian Correctional Management employ the high-risk assessment team (HRAT) approach developed in prison settings to manage suicide risk and self-harming behavior (Dudley, 2003). People who have engaged in acts of self-harm or who are considered to be at risk of future self-harm are placed on periodic observations from every 2 hours to every 2 minutes. In practice those placed on HRAT are generally placed in isolation to reduce the risk of completed suicide, with testimonial evidence suggesting that removal is often to a management block with cell-like rooms, sometimes without toilet facilities or may even involve removal to a police lockup (Four Corners, 2003). The HRAT alert will be maintained until the risk of self-harm is considered to have subsided, a decision that will often depend on assessment by health or mental health personnel. The HRAT regime appears aimed at avoiding liability for breaches of duty of care, which can result in suicide, and is not informed by notions of clinical care (Dudley, 2003). Individuals can be kept in effective isolation for days or week as a result of this approach. A psychiatric problem is recharacterized as a behavioral management program, with good behavior rewarded by release to the open detention compound. As argued by Dudley (2003), because the HRAT model does not address the contextual reasons driving self-harming behavior, it creates an environment of emotional escalation that leads inevitably to an endemic institutional culture of self-harm. The health care practitioner faces the dilemma of whether or not to identify a detainee under their care as being at risk of suicide or self-harm, knowing that the HRAT approach is aimed at the prevention of self-harm but not at the alleviation of the symptoms driving the behavior.

The management of hunger strikers also poses particular dilemmas for medical staff in detention, who are invested with the authority to request medical intervention to provide involuntary nourishment under the Australian Migration Act (Silove, Curtis, Masor, & Becker, 1996; Kenny, Silove, & Steel, 2004). General declarations relevant to the practice of all physicians emphasize respect for the autonomy of the individual and the right of the hunger striker to determine what shall be done with his or her own body. The 1975 Declaration of Tokyo, articulated at the 29th Congress of the World Medical Association, reinforces this principle: "Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially." The Declaration of Tokyo (World Medical Association, 1975) has been, since its adoption in 1975, the most comprehensive statement produced by the medical profession on the question of torture and cruel, inhuman, or degrading treatment of detainees (Amnesty International, 2000). More detailed ethical guidelines on the management of hunger

strikers have been articulated in the Declaration of Malta (World Medical Association, 1992) adopted by the 43rd assembly of the World Medical Association. While acknowledging the extreme difficulties faced by the physician in the management of hunger strikers the declaration reiterates the principle that:

> It is the duty of the doctor to respect the autonomy which the patient has over his person. A doctor requires informed consent from his patients before applying any of his skills to assist them, unless emergency circumstances have arisen in which case the doctor has to act in what is perceived to be the patient's best interests.

There appears to be little evidence that principles articulated in either the Tokyo or Malta Declarations are adhered to or even considered in the management of hunger strikers in Australian detention centers as reflected by the following exchange with the Australian Minister for Immigration on this issue.

> ***Damien Carrick:*** I also asked Phillip Ruddock if he was concerned that Australian doctors might be acting inconsistently with directives from the World Medical Association when it comes to the treatment of hunger strikers.
>
> ***Phillip Ruddock:*** Well I haven't got the faintest idea what some medical directions from overseas might be, and quite frankly, I don't care whether or not there is some international body that has a view about when you should force people to undertake certain procedures. We're not dealing with the sorts of situations where people would be making sensible decisions in relation to their own future, as they might if they were in the community, we're dealing with people who believe that they can manipulate government decision making by behaving in a way which may have quite adverse consequences for themselves, and that needs to be taken into account. (Law Report, 2002)

During 2001, 40 requests for the provision of involuntary nourishment to hunger strikers in Australian detention centers were authorized by the Immigration Department. The provision of a standard pro forma letter for such an intervention (see Figure 25.3) by the detention center provider creates an administrative framework that encourages and enables the treating physician to regard the provision of involuntary nourishment as a routine, ethically unproblematic, medical procedure. While the treating physician is not compelled to seek such an order, the provision of a pro forma letter encourages the doctor to act in a way that facilitates the control of the asylum seeker by the state.

Discussion of ethics generally focus on the individual practitioner as an autonomous moral agent, who must adhere to a set of ethical principles and guidelines (Beauchamp, 1999). However, it is the establishment of systems that undermines the independence and autonomy of the clinician

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I, being the undersigned registered medical practitioner am responsible for the care of the following detainee who is held at Curtin IRPC under the Migration Act 1958:
Name_____DOB:_____Curtin ID number_____

This detainee has been on voluntary starvation for_____days and his/her condition is now such that I have serious concern for his/her health and well being. He/She continues to refuse any food or fluids orally and if medical treatment is not given there will be serious risk to his or her life or health. Furthermore the detainee fails to give or is not capable of giving consent to medical treatment.

I am requesting Ministerial Instrument under Migration Regulations, Section 5.35, whereby medical treatment as defined by the Regulations may be given to this detainee, without his/her expressed consent for the shorter period of one week or the duration of this hunger strike. The need for any ongoing ministerial authority will be reviewed after one week.

Yours sincerely,

_____

Date:_____

Fig. 25.3 Copy of Pro Forma Letter Provided to Doctors to Authorize Involuntary Treatment for Hunger Strikers

that have historically seen the greatest abuses of health care practice (Chodoff, 1999). It should be noted that virtually all of the acute ethical dilemmas that face health care staff discussed above are a direct consequence of the coercive nature of the detention center environment. Participation in hunger strikes by asylum seekers living in the broader Australian community is virtually nonexistent (Silove et al., 1996). Similarly, while self-harm and suicide attempts undoubtedly occur in the

community, setting the evidence is that the rate is substantially lower than that manifest among immigration detainees (Dudley, 2003).

TOWARD A BLUEPRINT FOR ETHICAL PRACTICE IN DETENTION

> Be sure that you do not find yourself providing relaxation training to a patient who experiences panic attacks while the storm troopers kick down the door of their neighbour.
>
> Dr. Chris Clarke, School of Psychology, University of NSW, 1993

The best mental health practice incorporates a biopsychosocial approach to assessment, management, and intervention. The application of such a model is not possible in immigration detention as it has been practiced in Australia, despite the extraordinary high level of mental illness among detainees. Clinicians experience pressure to prescribe medication in the absence of a comprehensive intervention and are encouraged to ignore the impact of the environment on the ongoing trauma resulting from indefinite detention.

This raises significant questions about the clinician's role in a situation, where treatment planning, and intervention are unsuccessful for complex political and administrative reasons, predominantly the inability of clinicians to impact the detainee's psychosocial circumstances. The federal government has received advice from both mental health and child protection experts that for those adult and child detainees assessed, continuing indefinite detention is medically contraindicated. This raises a number of questions, for example, is it appropriate to continue to offer interventions when the detention context has been identified as the source of the current distress and clinically based recommendations have not been implemented? What is our responsibility, as individuals and as service providers, to these "unauthorized noncitizens" who we know to be in need, living on our soil but outside the structures that protect the rest of us from neglect, abuse, and degradation? Does "treatment" in this context amount to collusion or is it appropriate provision of support? If all your recommendations are ignored, should you keep making them?

Any answer to these questions must acknowledge that the detention of asylum seekers will continue to be practiced by a number of Western countries, at least in the short to medium term, and might expand in the near future. Government authorities or their detention contractors will continue to attempt to employ mental health professionals to ensure that they are seen to be meeting their duty of care obligations to detainees. Some mental health professionals, regardless of their own personal beliefs about the appropriateness of detention, will continue to work in these settings. Indeed it could be argued that the extreme mental distress of the detainees requires that mental health professionals play some

active role in providing care. Consequently, it is important to attempt to examine how a blueprint for ethical practice in detention can be established and maintained. At the outset it must be acknowledged that some of the ethical dilemmas confronting the mental health professional in the detention center environment are not dissimilar to those facing clinicians in other custodial settings, for which detailed ethical guidelines have already been developed and which are recommended to the reader (Prison Health Care Practitioners, 2003; Weinsetein et al., 2000;). Nevertheless, there are important differences that make the ethical dilemmas in detention considerably acute. Detainees have not committed or been alleged to commit any offense. They are detained indefinitely. There is no suggestion that immigration detention should involve any kind of correctional or rehabilitative component, often a major contextual factor influencing the rationale for the involvement of mental health professionals in other custodial settings. Most important, while the indefinite detention of asylum seekers is lawful in Australia, it is clearly in breach of international human rights commitments and obligations to which Australia is a signatory.

From the outset the clinician should be prepared to acknowledge that the asylum seekers for whom they care, particularly those who have been detained for protracted periods, can experience profound psychological deterioration and that they will be able to do little to prevent this process. They need to acknowledge the limitations of their own professional ability to care for and to treat detainees and to be careful that they do not inadvertently become yet another instrument of control. Many standard psychological treatments are based on the assumption that the negative emotional reactions being experienced by a patient are disproportionate to the real environmental circumstances in which they live. In the case of those being held in detention, however, this assumption is probably not warranted, and the appropriateness of such treatments is highly problematic, as is reflected in the above quote by Chris Clarke.

At a conceptual level consideration of the adaptational framework proposed by Silove (1999) for understanding the threats faced by survivors of mass trauma provides a theoretical framework for understanding the clinical role and associated limitations that face a clinician working in detention. This conceptual model identifies five broad domains: security and safety, attachment, justice, identity and role, and existential meaning, which can variously be affected by complex trauma including the trauma caused by indefinite detention. Pathology arises when a breakdown in one of the domains occurs. For example, a breakdown in security and safety is argued to pose a serious threat to the integrity of an individual and manifest pathologically as PTSD. Threats to the attachment domain, through the murder or disappearance of family or friends, is argued to lead to complicated grief reactions and violation of the justice domain. This can be caused by exposure to systematic human rights abuses and manifests as ongoing

pathological anger reactions. The focus of any intervention would thus reflect the system where evidence of the breakdown exists. For example, to ameliorate symptoms of PTSD restoration of the security/safety system would be the focus of any intervention.

This model provides useful insights into understanding the preconditions for effective clinical work within the detention environment. The model would suggest that if clear and ongoing threats to one or more of the domains, as proposed by Silove, continue to exist in detention, then attempts to provide a therapeutic intervention for the resulting pathological outcome without addressing the threats associated with the genesis of the symptoms will not lead to clinical improvement. Thus, attempts to treat the symptoms of PTSD using standard treatment interventions without addressing the core issue of security and safety could face unexpected difficulties. For example, treatments such as imaginal exposure or testimony therapy appear to rely on, at least in part, a core assumption of safety as a precondition for treatment, with exposure leading to a form of habituation to salient trauma cues that are dependent on those cues not being linked to real life salient threats. Detainees are kept in a state of chronic anticipatory stress regarding their futures. They are likely to have witnessed significant trauma within the detention center, and they face the ever present possibility of forced repatriation to a situation that can be life threatening. Although positive treatment outcomes with asylum seekers have been noted in other contexts (Chapter 10 in this volume), it is our experience that the trauma encountered in detention renders such treatments ineffective.

While helping to identify those clinical domains that are unlikely to be responsive to treatment, Silove's model also provides a framework for understanding why interventions that, for example, attempt to promote the empowerment of asylum seekers or that acknowledge the reality of their situation of entrapment and ongoing exposure to human rights abuses are important. The palpable feelings of anger and resentment experienced by detainees result from a profound sense of injustice at being indefinitely imprisoned by the very country that they fled to for protection. Interventions aimed at empowerment seek to provide detainees with the tools and abilities to seek redress against the injustices they are subject to. The extreme feelings of betrayal experienced by asylum seekers who naively believed that Western countries were committed to upholding humanitarian principles can provide a serious threat to the existential life-world of the asylum seeker, fundamentally threatening core beliefs in the benevolence and very capacity for goodness in people. The clinician, by forming a protective and caring alliance with the asylum seeker, helps to provide a counter to these ongoing threats.

At a practical level the clinician should be aligned with and advocate for the best interests of those under his or her care and resist at all times the temptation to adopt any antidetainee sentiments that exist in the broader cultural milieu of the detention center. The role of the clinician

in providing accurate and competent documentation of the mental state of detainees is often critical, both for refugee claims and in subsequent requests and appeals for community release. The clinician should not only keep accurate records but be certain that the detainees know that these records exist and that they are informed about the necessary procedures to obtain copies that could assist their claims for protection. Advocacy can also include encouraging detainees to keep their own records if possible (writings, drawings, etc). The clinician must be careful that the thresholds for reaching appropriate diagnoses are not modified to compensate for the environment of detention. The temptation of every clinician is to use diagnosis to differentiate the most unwell from the broader community of persons. However, it is possible, and previous research (Steel, 2003; Sultan & O'Sullivan, 2001; Thompson et al., 1998) would suggest, that the majority of those in detention can meet the criteria for psychiatric diagnosis. This is often best achieved by employing standardized diagnostic assessment instruments.

A key role that the clinician should play in detention is to help detainees negotiate their complex legal and administrative environments, which can often involve collaboration between legal and medical services in order to render the unintelligible intelligible and make the hidden transparent. This can include advising on and even encouraging acts of appropriate resistance to ensure their legality and to maximize their effectiveness. In short clinicians should help detainees to out-think the system that imprisons them. This could include informing detainees how they can lodge formal complaints regarding perceived breaches of their rights. There is nothing radical in these suggestions, in short they are all strategies to empower our clients to take control of their lives. It could be argued that a key clinical threat to those held in detention is that they are rendered powerless by the state. Any activity that the clinician can do to reempower them is a substantive clinical intervention. Perhaps the most important role of the clinician is to stand with and to unflinchingly testify to the suffering experienced and the culpability of the system that is producing this harm. We are not suggesting that clinicians act in a covert or secretive manner, but rather that they publicly position themselves as a clinical defender and advocate for detainees' rights and well-being. In comparison to the asylum seekers, health practitioners working in detention come from a position of acknowledged rights as citizens, employees, and professionals that they can draw on to provide as much protection to the asylum seekers as possible.

Unfortunately, it must be acknowledged that at times our ability as health professionals to form a protective and caring alliance with those subjected to indefinite detention become ethically too complex, and then even we become estranged from those we try to help, as is illustrated by the case study outlined in Figure 25.4.

The case concerns a baby, Ben, and his mother, Sonia. Sonia traveled to Australia on a valid visa and lodged a claim for refugee protection due to fears of being targeted by persons involved in criminal activities in her Eastern European home city. Because of the authorized manner of her travel to Australia, Sonia was allowed to live in the Australian community while her claims for refugee protection were assessed. During this time she formed a relationship with an Australian citizen and gave birth to Ben. Shortly after the birth, Sonia's application for refugee status in Australia was rejected at the final administrative level on technical grounds. She received notification that she had to leave Australia within 28 days and her failure to do so would result in Sonia being placed in immigration detention under threat of deportation. Ben, however, was afforded Australian residency by virtue of his father and was not detained, resulting in a 5-month-old child being forcibly separated from his mother.

Sonia and Ben's case attracted considerable media attention. Various refugee advocate groups and politicians became involved and prominent Australians wrote letters on her behalf. Sonia's lawyer approached two of us to prepare reports on Sonia's behalf. The case raises conflicting issues of law, psychiatric practice, and public health advocacy. Sonia's enforced separation from Ben meant that she could not continue breastfeeding. She received no support with this. The pregnancy had been unplanned, and she had developed a postpartum depression that required a mother-baby unit admission and medication. After Sonia was detained, the Family Court awarded Ben's father custody, because Sonia was in detention.

Ben's father could only bring Ben to the detention center 1 to 2 times weekly for approximately 1 hour each time. Sonia could not stop crying. This improved when a refugee advocacy group set up a volunteer transport roster. Ben had colds and persistent eczema and Sonia feared Ben's father did not attend to these. When Ben was sick, he was kept away from her. Sonia and Ben were both distressed by this.

We wrote to the Minister of Community Services indicating that family relationship assessments had not been considered in determining custody. Sonia's lawyer sought a "bonding and attachment report" regarding interim residence and contact, Ben's relationship to Sonia and his father, and whether if Sonia was deported, Ben should go with her or not. We observed a good attachment between Sonia and Ben, with Ben reaching out for his mother, settling easily with her, and using her as a secure base from which to observe us as strangers. We indicated that regular positive contact was of paramount importance to Ben's development, and recommended that contact increase, but stopped short of recommending that Ben stay in immigration detention with his mother overnight.

Sonia wanted Ben to stay overnight and Sonia's lawyer increasingly insisted on obtaining a report supporting this. However, it was the view of all the clinicians involved that this would send a contradictory message that could establish a precedent, potentially undermining the plan to remove all children in detention. We asked whether it was legal to have an Australian citizen in immigration detention overnight, and noted that the minister had varied immigration law to suit specific circumstances, for example, stating that women and children could be detained in the community. We suggested Sonia and Ben be admitted to a residential mothercraft hospital that could assess the mother-infant relationship and could facilitate overnight access outside detention, but the hospital declined to have asylum-seekers attended by guards on its premises. Sonia told us she would welcome overnight access some nights per week out of detention, but after further conversation with her lawyer, declined this proposal, and again insisted on overnight access in detention. Sonia hung up the phone while talking to us after we reclarified our position. Contact has now broken down. Sonia and some refugee advocates saw our position as "hardline." The lawyer made further attempts to get reports from another child psychiatrist to support Ben spending overnight periods in detention, but without success.

Fig. 25.4 Solomon's Choice

CONCLUSION

Our role as health care professionals exposes us to the harsh and brutal contest being played out between powerful first world countries seeking

to protect their borders and individuals seeking protection from persecution at any cost. We encounter firsthand the resulting shattered lives and broken spirits. In this contest our ethics require us to prevent what harm we can and to document what we cannot prevent.

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Paper 8

Mares, S. & Jureidini, J. (2012). Child and adolescent refugees and asylum seekers in Australia. In M. Dudley, D. Silove & F. Gale (Eds.), ***Mental health and human rights: Vision, praxis, and courage*** **(pp. 403-14). Oxford: Oxford University Press.**

This chapter, in a book published in 2012, presents a review of the conditions that faced asylum seekers, including children, who arrived in Australia between 2000 and 2011. We then examine the ethical and human rights implications of government policies that knowingly place already vulnerable children at risk of further adversity (Mares & Jureidini, 2012). This is another relatively early contribution to the literature on the ethics of Australia's immigration and border protection policies, in particular the justification of harm on the grounds of deterrence.

I was approached by the editors of this book to write the chapter, and I then invited Jon Jureidini to write it with me. I took 70% of the responsibility for drafting, contact with editors and final submission. Jureidini drafted the ethical arguments. Design and content of the paper were shared equally. The paper is reproduced with permission.

Chapter 20

Child and Adolescent Refugees and Asylum Seekers in Australia

The Ethics of Exposing Children to Suffering to Achieve Social Outcomes

Sarah Mares and Jon Jureidini

Introduction

As the movement of people across the globe has increased, a growing number of developed nations (including Australia, the US, and the UK) have implemented harsh immigration policies. The current chapter will present a review of the conditions that faced asylum seekers including children of arriving in Australia from 2000 until late 2007, and update figures to 2011. We consider the ethical and human rights implications of these harsh policies which exposed children to abuse and neglect with negative developmental and mental health outcomes. We also consider the ethical demands on health professionals who assess and attempt to treat children and their families who are harmed by immigration policy and practice.

The Australian government maintains an offshore resettlement programme for refugees and persons in need of humanitarian assistance who receive support and assistance with resettlement on arrival in Australia. These generous programmes stand in stark contrast to the reception given to asylum seekers arriving in Australia, who were, until recently, subject to indefinite mandatory detention and restricted access to community supports and services. Many were detained for several years, in remote, privately managed detention centres. From 2001, occupants of boats intercepted at sea were held in detention on offshore islands of Australia (Christmas Island), or on other Pacific nations such as Manus Island in Papua New Guinea and the Island State of Nauru. This was known as 'The Pacific Solution'. Asylum seekers had limited access to health, legal, and other services, and were often in complete social isolation.

For those ultimately found to meet Australia's refugee protection obligations, uncertainty continued. From 1999 to 2008, Temporary Protection Visas (TPV) were offered, providing only time-limited (three to five years) refuge with no security of stay, no right of return, and no capacity for family reunification. On expiry of the TPV, refugees were required to undertake a *de novo* review of their Refugee Status in order to gain further temporary protection. The difficulties faced by already traumatized adults and children were compounded by official and media use of dehumanizing and negative language, referring to asylum seekers as unauthorized non-citizens, illegal immigrants, queue jumpers, and potential terrorists (Klocker and Dunn 2003).

The harm to children and their caregivers went beyond the failure of the state to protect children from individual acts of abuse and neglect. Rather than being unwitting, the harm was justified by politicians on the grounds that it acted as a deterrent to further attempted migration or that providing more appropriate environments would encourage asylum seekers to bring

children in order to secure more favourable outcomes. The system was maintained despite increasing evidence of the negative health and mental health consequences for detainees and sustained public and professional opposition to these breaches of human rights.

Child asylum seekers and refugees

Forced migration is a major problem with increasing areas of regional armed conflict between and within nations, often complicated by environmental disaster, leading to increasing numbers of refugees, asylum seekers, and displaced persons fleeing persecution and danger. At the end of 2007, the total population under UNHCR's responsibility was 31.7 million. Information on the age breakdown is incomplete but suggests that, in refugees and refugee-like situations, 46 per cent of the refugee population are under 18, and 10 per cent are under the age of five (UNHCR 2008).

Asylum seeker and refugee children have a range of vulnerabilities related to their pre-flight experiences (Fazel and Stein 2002; Lustig et al. 2004), including exposure to violence (direct and witnessed), trauma, civil strife, family dislocation and loss and, for many families, years spent in substandard living conditions in refugee camps. Flight experiences for asylum seekers are often also traumatic. Since 1999, the journeys of those arriving in Australia frequently involve smuggling by boat from Indonesia to the northern offshore waters of Australia in overcrowded, unseaworthy vessels, many with young children on board. A number of maritime disasters and deaths have occurred as a consequence (Kevin 2004).

The experience of resettlement varies considerably depending on the welcome extended, and the way refugees are represented in the media and political debates. By definition, families found to be in need of refugee protection have not migrated voluntarily. Many live unwillingly in exile with ambivalent feelings about resettlement and the permanency of their new home. Marginalization and racism, or further traumatization during detention and the visa determination process, adversely affect the health and well-being of families and children. There is evidence that post-settlement experiences have a major impact on long term psychosocial adjustment of adult refugees and asylum seekers (Steel et al. 2006; Porter and Haslam 2005; Heptinstall et al. 2004).

The impact of immigration policies and practice on children and families—Australia as an example

Many thousands of children (0–18 years) were detained in Australia over the last decade. There are more children in immigration detention in early 2011 than ever before. In September 2001, at the height of the previous peak, there were 842 children in detention; in May 2011 there were 1,082 (Jureidini and Burnside 2011). It is assumed that, of the estimated 4089 children who arrived in Australia without valid visas between 1999 and 2003, most, if not all, were detained for some period, as until July 2005 no distinction was made in immigration law and practice between adults and children seeking asylum (Crock 2007).

Children are dependent on others to identify and meet their needs and therefore their well-being cannot be considered separately from that of their caregivers, and the wider social and cultural context (Bronfenbrenner 1979). Children who are separated from caregivers are particularly vulnerable. Two hundred and ninety unaccompanied minors, aged 8 to 17 years were detained in Australia between 1999 and 2003. For those who were detained with family, their incarcerated, traumatized, and disempowered parents and caregivers were often unable to adequately provide care and protection or fulfil parental roles and responsibilities. Separation from caregivers was offered as the only and inevitable consequence of removing children from

Box 20.1: International conventions and asylum-seekers

Australia is a signatory both to the UN Convention Relating to the Status of Refugees (UNHCR 1951) and the Convention on the Rights of the Child (CRC) (UN 1989). Under the Refugee Convention, incorporated into the Australian Migration Act, a refugee is defined as a person who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country. . .' (UNHCR 1951). Asylum seekers are those who have applied for protection from persecution under the UN Refugee Convention definition but have not yet received a final decision on their application. The United Nation's CRC outlines the human rights and protections to which children are entitled. In 1990, Australia ratified the CRC and this was scheduled into the Commonwealth Human Rights and Equal Opportunity Act in 1993. However, the provisions of the CRC have not been enacted in Australian law and Australia does not have a Bill of Rights. Article 3 of the CRC states

> 1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

The four core principles of the convention are non-discrimination; giving priority to the best interests of the child; the right to life, survival and development; and respect for the views of the child.
In relation to the importance of the family, the Preamble to the CRC states in part:

> Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community, . . .

Article 22 outlines the obligations of signatory states to refugee children:

> Parties shall take appropriate measures to ensure that a child who is seeking refugee status . . . shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties.

In relation to detention of children, Article 37(b) states:

> Parties shall ensure that: No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time.

UNHCR Revised Guidelines relating to the detention of Asylum Seekers Guideline 6 (UNHCR 1999) also state that 'detention is undesirable, should not be prolonged and that children should not be detained'.

immigration detention, resulting in a choice between two negative options for children and families: continued incarceration or family break-up.

Parental mental illness increases children's vulnerability to emotional and behavioural disorders and post-traumatic symptoms and developmental disruption in children are strongly linked to their parents' well-being and level of traumatization (Sack et al. 1995; Smith et al. 2001). There is

evidence of the adverse impact of parental and, in particular, maternal mental health on children's functioning both in situations of war trauma (Qouta et al. 2005; Smith et al. 2001) and while detained and seeking asylum (Mares et al. 2002; Mares and Jureidini 2004; Steel, Momartin, et al. 2004). There is also evidence that post-migration experiences have a significant impact on the mental health of refugee and asylum seeker adults and children (Porter and Haslam 2005; Steel et al. 2006).

Australia's policies have demonstrably had considerable negative mental health and developmental consequences for detained adults and children (Silove et al. 2007; Steel, Momartin, et al. 2004; Steel et al. 2006; Mares and Jureidini 2004; Momartin et al. 2006). Limited international studies support these findings (Ichikawa et al. 2006; Keller et al. 2003). Research with this population is difficult for a multitude of practical, ethical, and political reasons (Kirmayer et al. 2004; Minas 2004). Steel et al. (2004) surveyed a near complete sample of children and their caregivers in one remote detention facility. They concluded, 'All adults and children met diagnostic criteria for at least one current psychiatric disorder. Based on retrospective comparisons, adults displayed a threefold and children a tenfold increase in psychiatric disorder subsequent to detention' (p. 30). In another study (Mares and Jureidini 2004), all the children interviewed in remote detention facilities had witnessed repeated acts of self harm by their parents and other adults, including cutting, attempted hangings, self poisoning, and jumping onto razor wire. Many children had also harmed themselves. Parents felt considerable grief and guilt witnessing their children experiencing further trauma and disadvantage during prolonged periods in detention. In the detention centre setting parents were at times the source of their child's trauma as a result of their self-destructive or otherwise disturbed behaviour and mental illness.

> One young couple with an infant child lived in a donga with other unrelated detainees, from several different cultures. The tiny rooms within the donga were only separated by curtains. Many detainees became angry and complained that the infant was keeping them awake at night. The mother's response was to tape the child's mouth closed as an attempt to reduce conflict and danger. She was reported to the child protection agency but she and the child continued to be detained in the same environment.[1]

When parents or care givers are unable, for whatever reason, to provide care and protection, the state has a role 'in loco parentis' to ensure that children's needs are met. In Australia, as in many other countries, this is enshrined in child protection legislation. Australia invests considerable resources in child protection policies and programmes for its residents and citizens. Exposure to violence, physical, sexual, or emotional abuse, and neglect of children's developmental needs for love, care, and protection are all forms of maltreatment which ordinarily trigger state intervention.

> An 11 year old boy was left to care for his infant brother while his mother was in hospital with a medical condition. During that time he was sexually abused and when the state child protection agency confirmed that he had been abused, their intervention was to teach him protective behaviours so that he 'did not expose himself to the risk of further abuse'.

Detained children were knowingly exposed to violence, neglect, and abuse. Their developmental needs including education were not met and they were prevented from participation in the community and in decision-making about their lives. Australia's detention of refugee children

[1] These examples are adapted from the direct clinical experience of the authors and have been de-identified.

with their families and as unaccompanied minors breached children's human rights in many areas (HREOC 2004:Section 6.1, 138), and caused demonstrable harm to those detained, including children. The use of mistreatment as deterrent contravenes the 1985 United Nations High Commission for Refugees (UNHCR) Guidelines on the Detention of Asylum Seekers, which explicitly state that the use of detention to deter future asylum seekers is contrary to the principles of international protection.

The Australian government received much criticism from Australian and international bodies including the Office of the United Nations High Commissioner of Human Rights, who, in response to Australia's Migration (Further Border Protection Amendment) Bill 2002, stated detention 'for example as deterrent or as a punitive measure for illegal entry/presence is considered to be at variance with Article 31' (UNHCR 2002). These policies also resulted in sustained legal challenge (Burnside 2007) and community protest (Gosden 2006; Mares and Newman 2007).

Concerted public and professional opposition to these policies and a change of national government in November 2007 resulted in some changes to immigration policy and law including an end to detention of children (changed by regulation in 2005), indefinite detention, and Temporary Protection Visas (TPVs). The Rudd Labor government's stated key immigration values included 'mandatory detention as an essential component of strong border control', but that 'children, including juvenile foreign fishers and, where possible, their families, will not be detained in an immigration detention centre (IDC)' (Evans 2008a).

Despite this, since December 2008, the new multimillion dollar detention centre on Christmas Island (4000km from the nearest major city) has been used to detain asylum seekers. There is ongoing concern, including from members of the Parliament Standing Committee on Migration (2008) about aspects of current policy, in particular inadequate independent oversight, lack of protection against arbitrary detention, and the continuing use of off-shore detention with the associated difficulties of access to legal and medical support. Thus asylum-seeking adults and children arriving in Australia remain extremely vulnerable and detention, often in remote centres, remains standard practice. As at February 2011, there were 1027 children in immigration detention (Department of Immigration and Citizenship 2011).[2]

Deterrence as explicit policy

On 5 May 1992, the then Immigration Minister Gerry Hand made it explicit that detention legislation was intended as a deterrent.

> The Government is determined that a clear signal be sent that migration to Australia may not be achieved by simply arriving in this country and expecting to be allowed into the community. (Hand 1992)

Subsequent ministers reaffirmed this intent with specific reference to children in detention. For example, when the HREOC report was tabled in Parliament in May 2004, recommending the immediate release of all children from immigration detention (HREOC 2004), Senator Amanda Vanstone, Minister for Immigration and Multicultural Affairs and Attorney-General Philip Ruddock stated:

> The government's strong but fair border protection policies have had an impact. The number of unauthorized arrivals has dramatically reduced from 4,137 in 2000-01 to 82 in this financial year. This means

[2] <http://www.immi.gov.au/managing-australias-borders/detention/_pdf/immigration-detention-statistics-20110204.pdf>, accessed 3 April 2011.

> that the people smuggling trade has also reduced and children have not had to undertake a hazardous journey which may have jeopardised their lives (Vanstone and Ruddock 2004).

In the face of considerable public evidence about the harmful psychological impact of detention on children and families (HREOC 2004) such statements appear to justify the damage done to children and adults in immigration detention on the grounds that there is greater benefit to others through successfully discouraging further attempts to seek asylum.

A subsequent media release confirmed this intent: 'the success of the government's strategies to deter people smugglers has seen illegal arrivals virtually cease' (Vanstone 2004), as did earlier ministerial correspondence: 'the state has the sovereign right to determine which non-citizens can enter the country, those that can remain, and the conditions under which any may be removed. . . . While deterrence is not a primary purpose of detention, it is an important incidental factor' (Ruddock, personal communication to S Mares, 28 April 2003).

Ethical implications of deterrence as policy

There are complex national and international factors that contribute to the harsh immigration policies adopted by Australia. These include perceived threat to wealth and environmental sustainability from rising numbers of displaced people. There are also valid arguments about the right of a nation state to protect and manage its borders. Likewise a complex set of interacting factors influence changes in the origin and number of asylum seekers arriving in Australia. Our focus is on the ethics of Australia's chosen response to this set of circumstances.

In addition to being contrary to Australia's treaty obligations, we examine whether detention of children as a deterrent is unethical, and ultimately also damaging to the community that it is implied to protect or advantage. Leaving aside the substantial philosophical debate[3] about the ethics of using others as a means to an end, we consider the government's argument that use of immigration detention as deterrent can be defended on the grounds that any harm done is outweighed by the good achieved. This is a consequentialist argument, whereby an act is judged morally right or wrong depending only on its consequences. According to this approach, if a cost-benefit analysis demonstrates that the benefit of mandatory detention, including the use of children as deterrence, is greater than the 'cost', the action is ethical. Recently it has been claimed that consequentialist arguments can be used to defend the use of torture in certain circumstances. It is argued that the harm caused to the person being tortured, and the person carrying out the torture (by virtue of their 'good' being diminished by engaging in demeaning behaviour) is outweighed by the benefit. This is termed the 'ticking bomb' argument, whereby torturing a terrorist who has planted a bomb might elicit information that saves lives (Dershowitz 2006). There are a number of counterarguments, including the lack of demonstrated effectiveness of torture to elicit useful information (also see Chapter 13).

Inevitably such accounting exercises are prone to interpretation and bias, so that good evidence is needed to override the common sense conclusion that torture is inhumane or, in this case, that children should be protected. We contend that such evidence is not available to support the benefits of mandatory detention under this argument, so that even if we forego a moral

[3] Ethical concerns about situations in which good is secured for some people only if others suffer harm dates back to Kant: 'For all rational beings come under the law that each of them must treat itself and all others never merely as means, but in every case at the same time as ends in themselves. . . [each individual] has not merely a relative worth, i.e. value, but an intrinsic worth, that is, dignity', Kant, I (1785) *Groundwork for the Metaphysics of Morals*.

commitment to uphold and protect the well-being and the rights of asylum-seeking children and their families, we still cannot justify detention as deterrent.

Cost-benefit analysis

The first step in demonstrating favourable cost-benefit is to show that draconian measures are an effective deterrent. A causal relationship between Australia's inhumane treatment of asylum seeker adults and children, and decreasing number of boat arrivals was claimed but not demonstrated. Many other factors including political changes in origin countries and diplomatic work with Indonesia are likely to have contributed to the reduction in arrivals. The onus was on the Australian government to show that the proposed causal relationship was real, and the evidence for this is contested. Let us accept for the purposes of this argument that the possibility of a significant deterrent effect can be demonstrated.

The claimed benefits from deterring asylum seekers were:

Preventing their exploitation by people smugglers and reducing their exposure to dangerous travel in unsafe vessels

The most compelling ethical argument here is that individuals should be able to make autonomous decisions according to their own analysis of the circumstances. The fact that children are exposed to these risks by their parents without having any say in the decision raises the possibility that a third party, such as the Australian government, might have a mandate to intervene.

Fairness

Former Prime Minister Howard argued that Australia has a refugee quota that is 'quite generous' by world standards, with all asylum seekers having the right to apply to come to Australia in this way. Those who arrive by boat are then considered 'queue jumpers'. It is implied that taking too many refugees would overwhelm Australia's resources, and that the refugee assessment process must be 'fair'. This claimed benefit ignores the fact that there is no universally accessible or standardized system for refugee application. Many of the countries from which people come by boat have no 'queue' and the majority of countries do not have a refugee resettlement program but instead provide protection to asylum seekers.

Tough border protection as part of the 'War on Terror'

The argument was the need for vigilance lest one of the boat people be a terrorist. In practice, this argument found little or no empirical support, nor was it credible that terrorists would choose to enter the country through such a dangerous and circuitous route. Even if there was some merit to this concern, it was not demonstrated that detention was an effective strategy for managing this threat, with a range of community-based surveillance methods being utilized by security agencies in Australia for this purpose.

Against these claimed benefits are the costs of immigration detention. These include:

The risks and damage done to the families who do not come to Australia

There is insufficient data to quantify the potential harm caused by remaining in circumstances of persecution and danger which must be assumed to be significant.

The substantial widespread harm as a result of maltreatment of children while held in detention in Australia

These human costs are extensively documented (HREOC 2004) and include;

1. The direct effect of the harsh and depriving environment.
2. Exposure to violence and self destructive behaviour.
3. Loss of effective parenting due to the effect of the environment on parental mental health.
4. Failure of the state to adequately protect children when parents fail them or are unavailable.

Financial cost

The money spent on deterrence is unavailable for other opportunities in health, education, or overseas aid. It might be argued that deterrent policies have protected Australia from the social and economic costs of refugee processing and providing asylum. The monetary expense of running immigration detention and other deterrent policies seems likely to significantly outweigh the expense of taking asylum seekers into the community (Gauthier 2004). Former Minister Evans stated (17 November 2008):

> Neither humane nor fair, the Pacific Solution was also ineffective and wasteful. At massive cost to the Australian taxpayer—I am advised that the Department of Immigration and Citizenship expended $309.8 million between September 2001 and 29 February 2008 to run the Nauru and Manus OPCs—the Howard government sought to outsource our international protection obligations to less developed countries when we should have been shouldering them ourselves (Evans 2008b).

The cost to our national reputation, to our self-respect as citizens, and the human costs relating to harm done to those entrusted with enforcing the policy

These human costs have been considerable, resulting in the diminishment of Australia's reputation and to the national self concept as the land of the 'fair go'. Flouting of international human rights conventions can also be argued to undermine these conventions, with significant international consequences (Millbank 2004).

Taking into account the costs and benefits of justifying Australia's immigration policy, including detention of children and their families as deterrent, after some 20 years of policy implementation and development, there is evidence of both high human and material costs to individuals and to the nation, and little if any demonstrable evidence of benefit. Justification of harsh immigration policy as deterrence cannot be defended on the grounds that it can be demonstrated to achieve more good than harm.

Our final ethical point is that, if we take actions that increase a person's vulnerability, we have a greater responsibility to protect that person's welfare (Goodin 1985). Unaccompanied children, and those whose parents are incapacitated by physical or mental illness, are already vulnerable. If we wittingly add to that harm through using immigration detention as a deterrent, we render children more vulnerable by virtue of, increasing rather than diminishing our responsibility towards them. 'Someone who unwillingly suffers because of what we intend for him as a way of getting our larger goal seems to fall under our power and control in a distinctive way' (Quinn 1989:347–348). Because a person's vulnerability constitutes a reason to protect that person's welfare, responsibility for these people continues even if they are in a vulnerable position due to imprudent action, in this case, the decision to seek asylum in Australia. We argue that these vulnerable children are owed an increased duty of care by Convention Relating to the Status of Refugees and CRC signatory nations, including Australia, adding to our moral obligation to protect them.

Implications for clinicians

Clinicians who attempt to work with children and families affected by immigration policy encounter a system within which they have little power. Immigration law takes precedence over the health and child protection jurisdictions that ordinarily support the clinician's work, and this persists despite challenges in the Federal and Family Courts of Australia (Chisholm and Parkinson 2003; Freckelton 2003).

While breaches under international humanitarian law, especially of the provisions of the Convention of the Rights of the Child are unambiguous, the best response to this has not always been clear. Health professionals operate under various codes of professional conduct which are developed to inform and guide ethical professional practice. Few if any of these codes adequately anticipate the situation where a health professional is required to advocate actively against abusive government policies.

Within Australia and internationally in the political, public, and academic domains, arguments continue about the moral and ethical responsibilities of clinicians and researchers to this vulnerable population. Access to detention centres and detainees for the purposes of academic research is very limited and studies that have been undertaken were argued to be unscientific or unethical (Minas 2004). There has been little or no access to adequate clinical services for detained asylum seekers, especially those in remote centres. Medical staff employed by the private detention company have been required to sign confidentiality clauses preventing them from speaking about their observations of conditions in detention. This supports the argument made by some professional health groups that advocacy against an abusive and damaging immigration system has been preferable to employment in compromising circumstances, but this position is not universally accepted.

Despite the obstacles to detailed research information about the harmful effects of immigration policy on mental health, individual stories of harm and trauma, particularly of children, began to influence the public debate. A number of inquiries and reports (including HREOC) on the impact of immigration detention and harsh immigration policies generally were released that made the evidence increasingly difficult for politicians to dismiss. Public attention and sympathy were captured by the demonstrated harm occurring particularly to children, but it was the wrongful detention of a mentally ill Australian citizen that finally forced a government inquiry into the functioning of the immigration detention system.

Psychiatry has often been on the wrong side of the equation of human rights and mental health (Dudley and Gale 2002; Wilks 2005). In response to the human rights abuses outlined, child psychiatrists and other health professionals used knowledge of human development and the impact of trauma to demonstrate the damage done by immigration policy. They took an effective and lead role individually, as well as through professional organizations and in collaboration with community advocates, to argue for change to this policy in the political and the public domains. The emphasis was predominantly on the harmful clinical effects of detention, particularly on children rather than on the abuses of human rights, although the two were linked (Silove et al. 2007; Steel et al. 2004).

Despite the, at times considerable, personal and professional impact of these actions, we argue that health and mental health professionals are obliged to take a stand against these breaches. Health professionals have a responsibility to advocate for these already vulnerable adults and children and to remain vigilant in opposing state policies that damage one group of individuals with the stated aim of benefiting another. Not to do so is unethical and neglect of their professional duties and obligations.

Conclusion

The state, whether signatory or not to the Convention on the Rights of the Child, has a role in *loco parentis* to vulnerable children without effective parents. When state policies impact negatively on

the mental health and well-being of children and adults, this constitutes a breach of human rights. This failure of the state to protect children must be distinguished from even less acceptable practice whereby state policies, such as harsh immigration policies, use the stated aim of deterrence to justify and dismiss the negative consequences for children, young people, and their caregivers. In this chapter we have examined possible defences for the government against charges that they cruelly exploited the suffering of asylum seekers, including children, for the greater good. We have shown that arguments that the cost to the children is outweighed by the benefit to others cannot be sustained because evidence that harsh detention measures are effective as deterrence is inconclusive and the human cost of the intervention is substantial. We have also argued that we have a greater duty of care to these children because our actions made them more vulnerable. Health and mental health clinicians have an obligation to document and protest against such breaches of the rights of children and their caregivers, despite the multitude of ethical, personal, and professional challenges this inevitably involves.

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Paper 9

Mares, S. (2016). Fifteen years of detaining children who seek asylum in Australia – evidence and consequences. *Australasian Psychiatry, 24*(1), pp. 11–14.

This invited paper is a critical reflection on what was then 15 years of personal contact with children and families held in immigration detention, including the changing professional and political responses to immigration policy and research and writing about the impact of these policies. The aim was to review and summarise international and local evidence prior to 2015 on the impacts of mandatory indefinite detention of children and families who seek asylum in Australia. The paper includes description and analysis of the political narrative in Australia over this period, including in response to the AHRC inquiries in 2004 and 2014, and to the evidence about the mental health impacts of immigration detention (AHRC, 2014; HREOC, 2004). These reports contribute to the evidence and grey literature on immigration detention of children. There have also been significant political and cultural shifts in Australia following each inquiry and report, including the (at least temporary) removal of most children from closed detention facilities. The paper is reproduced with permission.

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Fifteen years of detaining children who seek asylum in Australia – evidence and consequences

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Abstract

Objective: To review and summarise the evidence about and consequences of Australia's policy of mandatory indefinite detention of children and families who arrive by boat to seek asylum.

Methods: This paper will summarise the accumulated scientific evidence about the health and mental health impacts of immigration detention on children and compare methodologies and discuss the political reception of the 2004 and 2014 Australian Human Rights Commission (AHRC) Inquiries into Immigration Detention of children.

Results: The conclusions of the 2004 and 2014 Inquiries into Immigration Detention of Children are consistent with Australian and international research which demonstrates that immigration detention has harmful health, mental health and developmental consequences for children and negative impacts on parenting.

Conclusion: The evidence that prolonged immigration detention causes psychological and developmental harm to children and families and is in breach of Australia's human rights obligations is consistent. This is now partially acknowledged by the Government. Attempts to limit public scrutiny through reduced access and potential punishment of medical witnesses arguably indicates the potency of their testimony. These harmful and unethical policies should be opposed.

Keywords: immigration detention, children and families, asylum seekers, human rights and mental health

Since 2001 the author has visited families in Australia's immigration detention centres and was appointed Royal Australian and New Zealand College of Psychiatrists (RANZCP) consultant to the 2014 Australian Human Rights Commission (AHRC) Inquiry into Immigration Detention of Children. The detention environment, distress of infants and children, and impact on family life is described elsewhere.[1] The AHRC consultancy was challenging: contact with large numbers of symptomatic children and adults; responsibility to listen and document stories without therapeutic authority; and a need to respect Inquiry decisions about what was discussed publicly, and when. The AHRC provided two sessions of debriefing after visits to Christmas Island.

The evidence

In 2002 the impact of the harsh physical and psychological environment of immigration detention on family functioning and vulnerable children was first documented.[2] Quantitative evidence of the harm caused to children followed,[3,4] adding to existing research on adults.[5] International studies[6] and review papers[7,8] have shown that even brief periods of detention impact on children's functioning. Host countries can support or undermine the wellbeing of asylum seeking children, post-migration detention and insecure asylum status being particularly detrimental.[9] In Australia there is the additional threat of transfer offshore. The particular vulnerability of unaccompanied children has been identified,[10] while the needs of infants and young children are underreported. There is a small literature on the wellbeing of pregnant asylum seekers.[11]

Research with detained populations is difficult for many practical and ethical reasons.[12] Despite this the findings are consistent: children in closed immigration detention have high levels of psychiatric disorder; there is a clear link between duration of detention and worsening men-

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tal health; and rates of mental disorder are higher than in refugees with similar levels of pre-migration risk who were not detained. These findings align with evidence of the developmental impacts of exposure to cumulative risks including parental mental illness and violence in an environment where protective factors are largely absent.

The Australian context

Mandatory indefinite detention of children and adults arriving in Australia without visas was introduced in 1992 and has been successively extended to include changes to the migration zone and offshore processing. Recently this has meant transfer of asylum seekers to Nauru or Manus Island (Papua New Guinea) for processing, precluding resettlement in Australia. Families remained on the remote offshore Christmas Island between July 2013 and late 2014 while this was negotiated. Reports of inadequate medical services, assault and hardship on Nauru and deaths of asylum seekers on Manus Island have added to extreme anxiety about offshore transfer and further doubts about the probity of Australia's policies.[13]

Human rights inquiries into immigration detention of children

In 2004 the Australian Human Rights and Equal Opportunity Commission (the name of the Australian Human Rights and Equal Opportunity Commission (HREOC) was changed to the Australian Human Rights Commission (AHRC) in 2009) published *A Last Resort; National Inquiry into Children in Immigration Detention*.[14] The human costs are extensively documented. Children are affected by the harsh inadequate environment, recurrent exposure to adult violence, self-harm and loss of effective parenting due to mental illness. HREOC found that the failure 'to protect and promote the mental health and development of children…not only constitutes a breach of a child's right to mental health, development and recovery, it also amounts to cruel, inhuman and degrading treatment'(p.13).[14]

This Inquiry was followed by amendments to the Migration Act 2005, affirming the principle that minors should be detained only as a last resort. Numbers of children detained fell dramatically between 2004 and 2009.

The AHRC maintained regular visits to immigration detention facilities between 2004 and 2014. Boat arrivals and detainee numbers again increased. By July 2013 there were 1992 children detained, averaging 231 days in March and 413 days detained by November 2014. Between January 2013 and March 2014, 128 infants were born into detention.[15]

Context

Between 2000 and 2002, during sustained protests in detention centres, children in detention were exposed to riot police, water cannons, tear gas and fires, and adults were injured and self-harming. A decade later protests continued but the violence was less overt. The systemic institutionalisation, dehumanising environment and the harsh developmentally inadequate context were replicated.[1,15] The legal situation in 2014 was more pervasively grim; hope of having refugee claims processed or of settling in Australia had been removed, a fact frequently restated to those seeking asylum. Many children were again deprived of adequate developmental experiences and exposed to adults, including parents, cutting, attempting to hang or poison themselves and being restrained.

In February 2014 the AHRC announced a second Inquiry. Of the 889 children including 56 unaccompanied minors then detained, 40% were under five years, 38% aged five to 12 and 22% were adolescent. *The Forgotten Children: National Inquiry into Children in Immigration Detention 2014* had public release in March 2015.[15] Numbers of children in closed detention had then fallen to 227 with 103 on Nauru.[16]

Neither Inquiry was given access to Nauru or Manus. The 2014 Inquiry included a chapter on Nauru AHRC, (p. 181) [15] based on UN High Commissioner for Refugees (UNHCR) and other site visits,[17] interviews with and submissions from medical, service staff and detainees and limited information provided by the Department of Immigration and Border Protection (DIBP).

Methodologies

A comparison of the methodologies and data sources for the 2004 and 2014 Inquiries is provided in Table 1. Specifically in 2014 a semi-structured interview was completed with 1129 detained children and families, providing a more robust approach to data collection. That Report also used a developmental orientation to highlight the particular needs of expectant families; those with infants, (pertinent given the 40% of children under five); the distress of children denied schooling; the anxieties for adolescents and additional vulnerability of unaccompanied children.[15] The DIBP reportedly also sought to conceal IHMS data showing that 34% of detained children had symptoms of moderate to severe mental disorder.[15: p.61]

Inquiry conclusions and recommendations

Both Inquiries report discrepancies between reports from asylum seekers, policy documents and evidence from DIBP, Serco and IHMS staff[14: p.38; 15: p.46]. Also language was at times deceptive. The 2014 Inquiry heard that all children have a 'Best Interests Assessment' before they are transferred to Nauru, but found that 'By the Department's own explanation, the best interests of an individual child has no bearing on whether that child is to be transferred to Nauru…it is the view of the Commission that the Best Interests Assessment for children, is in name only'[15: p.192].

Table 1. Methodologies and Data Sources – 2004 and 2014 Inquiries into Children in Detention

	Timeframe	*Report*	*Detention centre visits*	*Public hearings (witness numbers)*	*Submissions*	*Interviews*	*Access to Nauru and Manus*
HREOC *A Last Resort* 2004	Inquiry Nov. 2001–Dec. 2002 Concerned children detained 1999–2002	Presented April 2004 Tabled May 2004	11	61 public hearings (105) 24 confidential hearings (50)	346	112 interviews	No
AHRC *The Forgotten Children*	Feb.–Oct. 2014	Presented Nov. 2014 Tabled March 2015	11	Five public hearings (41)	230	1129 adults and children Semi- structured interviews with current detainees; 104 with former detainees	No Includes a chapter on Nauru

HREOC: Australian Human Rights and Equal Opportunity Commission; AHRC: Australian Human Rights Commission.

The conclusion of the two Inquiries is similar and in line with scientific studies: 'Prolonged, mandatory detention of asylum seeker children causes them significant mental and physical illness and developmental delays, in breach of Australia's international obligations'[15: p.13]

Both Reports make similar recommendations: that Australia comply with obligations under the Refugee Convention and Convention on the Rights of the Child; detained children and families be immediately housed in the community; the Migration Act be amended to ensure that children are detained for a strictly limited period; timely processing of refugee claims and an independent guardian for unaccompanied children.

Reception of the Inquiries

The political reception of the two reports differed. In 2004 the evidence of the harms caused by Immigration detention was in some ways 'new' and while the findings of HREOC were disputed, there was no sustained attack on the Human Rights body itself, and protective amendments to the Migration Act followed.

In 2015 *The Forgotten Children* report was received with great political hostility, including claims that the AHRC President had lost the Government's confidence and should step aside.[18] There was less attempt to deny the evidence that detention causes harm; rather a sustained 'attack on the messenger', including a suggestion of 'overreliance on the Commission's own experts'[15: p.308]. Attempts to limit public scrutiny and silence medical witnesses through increasingly restrictive employment contracts and legislation have followed.[19]

During Public Hearings a senior official in the DIBP had acknowledged the impact of immigration detention: '…there is a reasonably solid literature base which we're not contesting…which associates a length of detention with a whole range of adverse health conditions…' (DIBP Secretary M Bowles)[15: p.61]

Thus the harm caused to asylum seekers is accurately described as 'predictable and foreseeable',[20] unethical and in breach of our human rights obligations.[21,22] Given this, significant ethical challenges face doctors working within the immigration detention system.[18,23,24]

Conclusions

The tide of adults and children who seek asylum will continue and it is clear that humane geopolitical and regional responses are necessary. The findings of two Human Rights Inquiries into Immigration detention of children are supported by scientific evidence. The harm caused by current immigration policies is undeniable, and partially acknowledged by the Government. Australia's immigration policies and practices can be described as deliberate and informed. They are unethical, infringe the human rights of those detained, knowingly cause suffering and breach our international obligations. Attempts to limit public scrutiny and silence medical witnesses indicate the potency of testimony by health practitioners. There is no defence of ignorance. The human rights violations and consequent evidence of psychological harm to children and adults are very clear. As individuals and as a profession we have an obligation to oppose these policies.

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Paper 10

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This invited editorial was written collaboratively, and responsibility for content, editing and publication of the paper was shared equally with Derrick Silove. The paper provided an opportunity to review and reflect on the contribution of psychiatric and allied mental health professionals to evidence about the impact of Australia's policy and practice of indefinite mandatory detention of asylum seekers who arrive by boat. The aim was to summarise work that has occurred over 25 years and that might usefully inform health professionals working with similar population and in equally complex contexts. The accumulated evidence includes personal experience, research studies, witness accounts, reports by human rights organisations, clinical observations and commentaries. The paper identifies the work as sitting at the intersection of mental health, human rights, ethics and social policy and argues that the knowledge, skills and experience of psychiatrists position them to expertly reflect on and reflect back these issues to governments and the wider society. The paper is reproduced with permission.

Discussion

The post-independence law reforms in FYR of Macedonia provide substantial and procedural protection for the rights of patients with mental disorders, and they are in line with international best practice. The FYR of Macedonia has had a Mental Health Policy (Law on Mental Health, 2006) and mental health legislation since 2005. There is a national human rights review body that performs regular inspections and reviews complaints processes. However, there is a disparity between the law and its implementation in practice which is mainly due to an unjustified delay in legislating compulsory hospitalisation. The provisions from paragraph 2 of article 59 in the Non-Litigation Law (2008) are not fully implemented. More specifically, in everyday practice there are difficulties in procuring two adult witnesses who would fulfil the legally binding preconditions. In summary, the huge delays in legislating forced detention in FYR of Macedonia stems from the lack of collaboration between the court and the mental health institutions.

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EDITORIAL

The mental health of asylum seekers in Australia and the role of psychiatrists

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There are more displaced people around the world than ever before, and over half are children. Australia and other wealthy nations have implemented increasingly harsh policies, justified as 'humane deterrence', and aimed at preventing asylum seekers (persons without preestablished resettlement visas) from entering their borders and gaining protection. Australian psychiatrists and other health professionals have documented the impact of these harsh policies since their inception. Their experience in identifying and challenging the effects of these policies on the mental health of asylum seekers may prove instructive to others facing similar issues. In outlining the Australian experience, we draw selectively on personal experience, research, witness account issues, reports by human rights organisations, clinical observations and commentaries. Australia's harsh response to asylum seekers, including indefinite mandatory detention and denial of permanent protection for those found to be refugees, starkly demonstrates the ineluctable intersection of mental health, human rights, ethics and social policy, a complexity that the profession is uniquely positioned to understand and hence reflect back to government and the wider society.

The Office of the United Nations High Commissioner for Refugees estimates the global number of refugees to stand at an unprecedented 65.3 million, with 50% being children (UNHCR, 2017). Most receive sanctuary in neighbouring countries, a small percentage reaching North America, Europe and Australasia. Despite this, Australia and other wealthy nations have implemented increasingly harsh policies of so-called 'humane deterrence', aimed at preventing asylum seekers (persons without preestablished resettlement visas) from entering their borders.

The experiences of Australian psychiatrists and allied health professionals in confronting the mental health effects of these policies on asylum seekers may prove instructive to colleagues in other countries facing similar issues. In outlining the Australian experience, we draw selectively on personal experience, research, witness accounts, reports by human rights organisations, clinical observations and commentaries.

Australia's history of migration

Australia was invaded and colonised by the British around 1788 and is now a diverse multicultural nation. Apart from general immigrants, Australia ranks high in per capita intake of refugees accepted for resettlement overseas, that is, the off-shore program (RCA, 2015). Until the 1970s, this conformed to the White Australia policy, when a political transformation led to the acceptance of substantial numbers of South-east Asian refugees who were provided with unrestricted rights to education, work, income support, healthcare and citizenship. The enlightened nature of this resettlement policy is likely to have contributed to the remarkably sound mental health outcomes recorded for the Vietnamese two decades later (Steel *et al*, 2002).

Policies of deterrence

The late 1980s was a critical turning point politically as increasing numbers of asylum seekers arrived by boat on Australia's northern coast. In 1992 the government ushered in a two-tier policy: Australia accepts between 12 000 and 20 000 'off-shore' refugees screened overseas and supported in resettlement. In parallel, an increasingly harsh policy of deterrence applies in relation to asylum seekers, particularly those arriving by boat. Although policy has varied, there has been increasing reliance on mandatory indefinite detention applied to particular categories of asylum seekers. Many adults and children have been held for long periods in remote, prison-like detention centres and, more recently, on pacific island nations north of Australia. Other asylum seekers reside temporarily in the community under restrictive conditions, with limited rights to work, healthcare, education and family reunion. The details and harshness of these policies have fluctuated in step with prevailing political and public opinion.

Since 2013, a policy has been in place mandating the transfer of all sea arrivals to the island of Nauru (one of the smallest, least populous and under-resourced nations in Oceania) and Manus Island in Papua New Guinea. Many detainees have been held for over 4 years despite incidents of violence, abuse and self-harm, including violent deaths of detainees. The policy has remained steadfast, the prohibition against any detainee ever settling in Australia remaining in place, despite over 90% of detainees being identified as legitimate refugees after rigorous screening. A turning point came with the judicial ruling in Papua New Guinea that the Manus Island detention centre was illegal, leading to a hasty closure of the facility. This action provoked a humanitarian crisis in late 2017, when 600 inmates refused to leave, preferring to live without water, food and services than to be resettled in the general island community where, after prior incidents of violence directed at them, they feared for their safety. Nevertheless, the closure has generated some impetus to arrange resettlement of detainees from Nauru in other countries.

Roles of psychiatrists and allied health professionals

For 25 years, Australia psychiatrists and allied health colleagues have played important roles in responding to the treatment of asylum seekers.

Identifying the risks and awareness raising

From the outset, reports and commentaries by psychiatrists and other health professionals drew attention to the potential re-traumatising effects of detention and other restrictive policies on a population exposed to prior persecution and mass violence (Silove *et al*, 1993), Insider testimony, including from a detained doctor, provided support for these assertions. Since that time, psychiatrists have remained prominent in raising concerns and providing expert testimony about the mental health effect of the detention policy in the media, with the issue drawing national and worldwide attention through editorials in major international journals (e.g. Silove *et al*, 2001).

Documentation and research

There are significant challenges in undertaking research in this field, including gaining informed consent and other ethical constraints, access to asylum seekers, representativeness of samples and transcultural and language issues in assessment and measurement.

Despite this, research was initiated among adult asylum seekers soon after restrictive policies were implemented. The findings paint a consistent picture of markedly elevated rates of mental distress (including symptoms of post-traumatic stress, depression and anxiety) among asylum seekers compared with compatriot refugees with permanent residency status. In addition, the dual experience of detention and release on temporary protection visas was found to be associated with persisting traumatic stress symptoms and functional impairment (Steel *et al*, 2006).

Despite formidable obstacles in access, initial observations of children in remote Australian detention centres (Mares *et al*, 2002) and mixed method studies (Mares & Jureidini, 2004; Steel *et al*, 2004) converged to reveal extraordinarily high rates of a wide range of psychiatric disorders in children and their parents (Mares, 2016). This accruing body of evidence, buttressed by data collected under the authorities' own auspices (Young & Gordon, 2016), has played a discernible role in changing government responses over time. From a position of denial of the mental health harm being done and/or dismissing or denigrating the 'messengers', the tendency now is to tacitly accept and justify the duress caused in terms of protecting borders and humane deterrence; that is, the saving of lives following drownings of

Table 1
Asylum policy and mental health; principles derived from accrued evidence

1.	Successful adaptation and resettlement of refugees is supported by post arrival access to education, health and language services and pathways to citizenship.
2.	Refugee mental health is undermined by post-migration stressors, in particular prolonged immigration detention and temporary protection.
3.	Mental health is significantly worsened in asylum seekers who experience prolonged detention compared with those never detained.
4.	Detained children are exposed to multiple and cumulative risks with substantial negative effects on health, development and family functioning.
5.	Rates of mental illness in detained adults and children resemble clinical populations and morbidity increases with length of time detained.

asylum seekers at sea. The evidence accrued in Australia is summarised in Table 1.

Expert assessments

Evidence provided by psychiatrists, other health professionals and lawyers has proven pivotal in a series of inquiries into the effect of asylum policies by human rights groups, including the Australian Human Rights Commission and the United Nations Rapporteur on Human Rights (HREOC, 2004; AHRC, 2014). Mental health professionals and lawyers developed comprehensive protocols and training materials to assist the comprehensive assessment of refugee claims to limit risk of distorted testimonies, which result in erroneous decision-making. Among the factors that require sensitive consideration are risk of cultural and linguistic misunderstandings, the effect of post-traumatic stress disorder and depressive symptoms on the capacity to provide a coherent narrative, the importance of not overlooking the effect of past head injury on cognition and memory, eliciting histories of politically motivated sexual abuse and recognising reticence arising from underlying fears of reprisal against the self and the family.

Forging collaborations

Psychiatrists assumed leadership roles in forging collaborative networks within medical and allied professional groups. This strengthened the authority of these coalitions in attempts to influence policy. The solidarity achieved among diverse groups was unprecedented in Australia, particularly in the pursuit of a single but politicised health issue.

Risks and costs

Colleagues have taken contrasting positions on the ethical challenges involved in this highly politicised work (Newman, 2016). Attempts to collaborate with government on asylum issues have largely failed. Senior psychiatrists who initially contributed to a detention health advisory committee ultimately determined that the risks of unintended collusion outweighed potential gains. Employees of private health providers in detention centres, including individual psychiatrists and other colleagues, continue to speak out against the compromised care and deleterious effect of conditions in detention, risking potential prosecution (Dudley, 2016). In response, the Royal Australian and New Zealand College of Psychiatrists recently updated its guidelines for psychiatrists working in Australian immigration detention centres.

Attempts have been made to undermine the veracity of research findings and public testimony of medical experts, including psychiatrists (see Maglen, 2007), and to discourage psychiatrists and allied professionals from pursuing research in this area by refusing access or making access difficult. Until recently, legislation made it an offence for a range of professionals to divulge any information based on their observations

Table 2
Lessons from the experiences of psychiatrists working with asylum seekers in Australia

1.	The health and mental health of people who seek asylum cannot be considered in isolation from broader social and political factors.
2.	Immigration detention illustrates the intersection of human rights and mental health, leading to an overlap in roles of clinician, researcher and advocate.
3.	It is almost impossible to undertake studies with detained populations in conventional ways. The results invariably will be contentious and politicised. Nonetheless, research into the effects of restrictive government policies should be supported, and pressure brought to bear to allow access to representative samples without risk to investigators or participants.
4.	Health professionals working within the Australian immigration detention system face major ethical challenges. It is a system that causes demonstrable harm and lacks independent oversight and transparency.
5.	Clinicians and researcher in this area require the ongoing support of colleagues and professional bodies.

while working in detention centres (Dudley, 2016).

Individual psychiatrists have challenged the ethics of unconventional approaches to obtaining research data in this field, the two sides of the debate being aired in an issue of a bioethics journal devoted to the topic (Minas, 2004). Despite detractors, the urgency of undertaking research and the risk of silence on this topic was supported by both local and international colleagues (e.g. Kirmayer *et al*, 2004). A summary of the lessons learned is provided in Table 2.

Conclusion

Psychiatrists and allied professionals have played a sustained role in garnering and publicising evidence of the mental health consequences of Australia's harsh immigration policies. The evidence is clear: restrictive policies, particularly prolonged immigration detention, are detrimental to the mental health of adult and child asylum seekers. It is of particular importance that psychiatrists have raised concerns and generated evidence soon after implementation of restrictive policies, undermining government claims of ignorance of the harm done by continuing these harsh policies over subsequent decades.

Over time, the effects of detention on children have proved most persuasive in swaying public opinion. Although few children remain in detention (some are held on Nauru), many thousands remain in a state of limbo in the community either on temporary visas or community variants of detention, and the restrictive policies applied to children seeking asylum remain.

Unsurprisingly, commitment to this area of public policy and human rights comes at a cost to those involved. The evidence has been variously challenged, denied, undermined, ignored or justified. Health professionals must grapple with the unresolvable dilemma of a commitment to assisting detained asylum seekers while simultaneously recognising the ethical and professional compromises inherent in working within a detention regime that lacks independent scrutiny or oversight and demonstrably creates the conditions that cause the very harms that mental health professionals aim to prevent and remediate.

Despite the challenges, we maintain that it is the core business of psychiatrists to document, research and bear witness to the consequences of social policies that undermine the mental health of vulnerable populations. The billions of dollars expended on Australia's detention regime would be better spent on resourcing effective preventative and therapeutic interventions for displaced and traumatised people. Australia's policy and practise of indefinite mandatory detention of asylum seekers starkly demonstrates the ineluctable intersection of mental health, human rights and ethics, and social policy, a complex maze that the profession is uniquely positioned to understand and hence reflect back to both governments and the wider society.

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7.2 Conclusion

The 10 publications that make up Chapters 6 and 7 are evidence of a sustained commitment since 2002 to collection, analysis and publication of data about the mental health consequences for detained people and the implications for health professionals of Australia's policy of mandatory immigration detention of children and families who seek asylum. The findings are detailed in the individual papers and will not be reiterated except in the service of discussing their implications for theory and practice. The next chapter integrates the evidence to propose a framework for understanding the impact of immigration detention on children and considers the implications of the findings for health professionals.

Chapter 8: Discussion

8.1 Overview

This penultimate chapter brings together discussion threads that run through the previous chapters and the included papers. This is not work that has been undertaken in a laboratory or a library. It has occurred, is about and belongs in the world of people, policy and practice. The initial chapters provided the historical and political context in which this work was undertaken, introduced the concept of the 'refugee journey' and a conceptual framework for considering the developmental impacts of childhood adversity, and summarised what is known about the mental health of refugee children and families. This context included findings from a scoping review of current publications on the mental health of detained children and families who have been held in immigration detention. There was a chapter on the methodological approaches used, and in Chapter 6 and 7 the papers at the heart of the thesis were included in full. Chapter 6 also included a section on the children's drawings and discussion of what they convey.

This chapter begins with new and unpublished integration of data in relation to the mental health of children and families who are held in closed immigration detention. Based on the findings of this research and the extant literature, a framework is outlined that illustrates how and why immigration detention is harmful for children. The strengths and limitations of the work are identified and the implications of the findings for health professionals are discussed. This includes reflection on the role of clinicians in advocacy and the experience of 'witnessing'. Future priorities are identified.

8.2 The impact of immigration detention on children

The framework to be outlined here builds on the evidence presented so far provided in this thesis that it is inadequate and unethical to consider the distress and disorders suffered by detained children primarily in terms of individual and/or family psychopathology. Their suffering is inextricable from the environment of detention, the sociopolitical and cultural context within which this occurs, and the trauma they have experienced (Mares, 2016a, 2016b; Mares & Jureidini, 2004; Mares et al., 2002; Mares & Zwi, 2015; Zwi & Mares, 2015). The framework extends the ecological model to incorporate the passage of time, the

cumulative adversities experienced in immigration detention, and the developmental impact for detained children. This framework is a useful prelude to considering the practical and ethical implications of the findings.

Development, health and adversity – reconsidering the models

Several approaches to understanding child development and health in context and the impact of childhood adversity were introduced in Chapter 3. Here they are used to provide a scaffold on which to articulate the interacting factors involved in the generation of mental illness in detained children.

The ecological model introduced in Chapter 3 illustrates child development as 'nested' within interacting family, community and broader cultural and global systems, and argues that these are mutually transactional (Bronfenbrenner, 1977; Bronfenbrenner & Ceci, 1994). This much-adapted schema is consistent with a focus on the social determinants of health (Marmot et al., 2012). The model has been adapted and applied to the circumstances of refugee children (Grant & Guerin, 2014; Lustig, 2010; Williams, 2010; Miles et al., 2019). Lustig emphasises 'chaos' or disruption in all levels of refugee children's 'social ecology', and while Lustig does not specifically include immigration detention it is clear that the risk factors he identifies are significantly increased for children detained for immigration purposes (Lustig, 2010). The ADAPT model (Silove, 2013) identifies the social, community and institutional disruptions associated with displacement and resettlement, highlighting the institutionalised disadvantage and limbo state in which detained people are held (Silove & Mares, 2019).

The biopsychosocial model highlights the influence of social context on children's physical and psychological health and how inseparable these are in development. Many detained parents when interviewed, expressed additional concerns about their children's physical health development. Their concerns were supported by my observations in detention centres (Mares & Jureidini, 2004; Mares & Zwi, 2015), and other studies showing the increased health and developmental vulnerabilities of refugee children (Hanes et al., 2019; Lorek et al., 2009). These increased health needs highlight the importance of access to quality independent and specialist health care for children and families who seek asylum, on reception and during any period of detention.

The developmental impacts of cumulative adversity during childhood conceptualised along the dimensions of threat and deprivation can be aligned with pillars of the Convention on the Rights of the Child (CRC). Deprivation stands in contrast to provision of human rights as well as basic and developmental needs. Threat indicates a lack of protection, and the right to participation (denied by detention) is based on recognition and respect for children's personhood and agency.

The passage of time

Temporal factors relevant to the experience of detained children include the stages of the refugee journey, the developmental imperative, the duration of detention and the impact on future orientation. Bronfenbrenner's schema was adapted in a systematic review paper by Reed and colleagues to include 'the chronological dimension', the stages of the refugee journey past and present (Reed et al., 2012, p. 258). This was included earlier (Chapter 3 Figure 3.3). The other temporal elements will be discussed here.

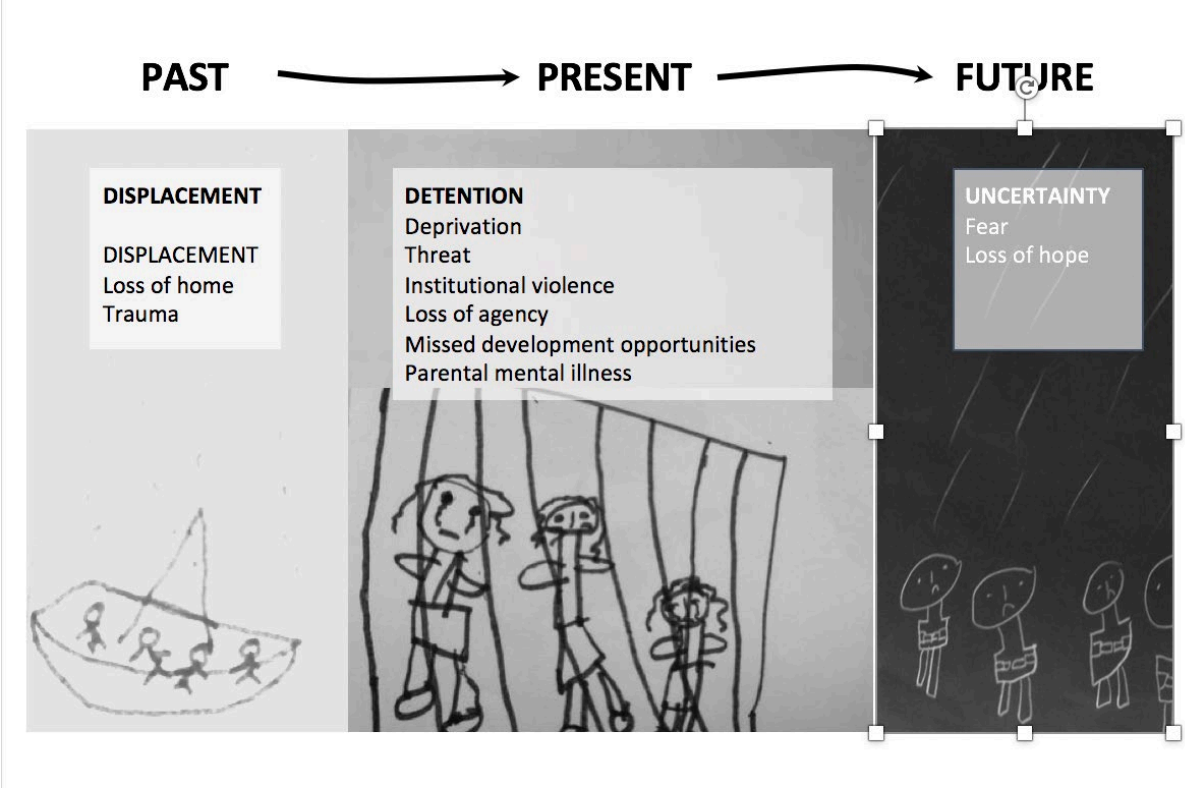
Children's development cannot wait. It continues to unfold in response to experience and environment. A developmental perspective considers the age of the child and the biopsychosocial impact of exposure to risk and protective factors at different developmental stages. For many displaced children this includes parental loss, deprivation or neglect, and exposure to violence. The timing has neurobiological significance in light of evidence about sensitive periods in development (Knudsen, 2004) and salience in relation to the meaning and sense children are able to make of their experience. Vignettes in the publications included in the thesis (Mares & Jureidini, 2004; Mares et al., 2002; Mares & Zwi, 2015; Zwi & Mares, 2015), and elsewhere (Mares & Powrie, 2008), illustrate the impact of adverse exposure during immigration detention on children at different ages and in differing circumstances.

Even relatively brief periods of detention, days or weeks, can result in children becoming symptomatic (Kronick et al., 2015; Lorek et al., 2009; MacLean et al., 2019). However, duration of detention is significant. These children are growing up inside the detention facility, and when detention is prolonged they move from one developmental stage to the next – infancy to childhood or adolescence to becoming adult. Detention delays the opportunity to settle and heal, and over time vulnerable children continue to miss out on

acquisition of skills and competencies while being exposed to further adversity. The policy and practice of indefinite detention, threat of deportation and reduced resettlement options constrict future possibilities, remove hope and increase fear about the future, with impacts on hopefulness, agency and resilience. This is discussed further below.

In Figure 8.1 the stages of the journey – passage of time, duration of detention, and fear/loss of hope for children who are detained – are illustrated using excerpts from some of the drawings included in the papers and Chapter 6.

Figure 8.1: The passage of time



An ecological framework

The global environment

A modification of the schema used to represent the ecological model (Bronfenbrenner & Ceci, 1994; Sameroff, 2010) provides a useful starting place to consider the contextual experience of children in immigration detention. The most distal sphere or 'macrosystem' (Bronfenbrenner, 1977) is defined here as geopolitical influences (Sameroff, 2010). Relevant global factors include the increasing number of people forcibly displaced by war, persecution

and the changing climate, increasingly aggressive international rhetoric about border control, and a waning regard for the 1950 Refugee Convention (McAdam, 2017). Social media enables access to and exposure of detained people to information and misinformation about how their circumstances and motives are reported, as well as the situation in their own country and in Australia. In this way the global context has a continuing psychological as well as material impact on asylum seekers who are detained.

The national environment

The next sphere, the 'exosystem' in Bronfenbrenner's terms, includes the national policy framework, political milieu and public discourse in which detention of asylum seekers occurs. In Australia there are contradictory public narratives whereby children and young people held in detention are variously portrayed as potential security threats, victims of parental decisions or tools used in attempts at government manipulation. An extreme example of this was the 'children overboard affair' (Rose, 2016). Fiske writes, "The dominant narrative surrounding refugees and asylum seekers … is one in which the refugee is viewed either as a victim or a villain. Possible responses are consequently narrowed to charity or hostility" (Fiske, 2016, p. 5).

At a socio-cultural level, the Australian national narrative about asylum seekers is polarised, stigmatising and predominantly negative. It is frequently linked to cultural and religious identity and threat (Augoustinos, Due & Callaghan, 2018). This makes identification as an 'asylum seeker' extremely problematic and has particular significance when cultural or religious identity may have contributed to children's displacement from home and resultant family separation and loss. Detained children are held involuntarily at the stage of developing their own sense of themselves. It is a stage of considerable sensitivity to representation and misrepresentation by others. The drawings and words of the detained children presented in this thesis indicate a strong sense of injustice about the way they are treated and are represented in global and national narratives. The impact on identity formation of current border protection policies and stigmatisation in national narratives is difficult to quantify.

Asylum seekers have lost their home, their community, and the cultural and institutional structures that framed their lives. They are denied access to a place in the Australian community or the protections and social supports available to other temporary visa holders. They cannot begin the process of resettlement and instead are required to adapt to an inflexible penal environment where social structures are replaced by hierarchical routines, with limited access to justice and support and few opportunities for participation or meaningful activity.

The institutional environment

In the ecological scheme the 'mesosystem' contains the "specific social structures, both formal and informal, that …. impinge upon or encompass the immediate settings in which that person is found, and thereby influence, delimit, or even determine what goes on there" (Bronfenbrenner, 1977, p. 515). This defines the immigration detention system: an 'involuntary community' of adults, children and families held indefinitely in a closed penal setting. There are multiple human rights breaches associated with mandatory detention, as confirmed in two AHRC inquiries (AHRC, 2014; HREOC, 2004). It is an institution where officers have power. As a direct consequence of being detained, children are exposed to interpersonal conflict, acts of violent self-harm, and institutional experiences that are dehumanising (Mares, 2016a). They have limited access to schooling and independent health care (Mares & Jureidini, 2004; Mares et al., 2002; Mares & Zwi, 2015; Zwi & Mares, 2015).

The additional element is the power invested in the officers and the detention system. While this circumstance can impose or maintain order, it can also be enacted as administrative violence, such as the use of numbers not names and the imposition of solitary confinement for young people whose behaviour is considered disruptive. Similar experiences are reported in studies of adult asylum seekers detained in Australia (Coffey, Kaplan, Sampson & Tucci, 2010) and in Canada (Cleveland, Kronick, Gros & Rousseau, 2018). There are recent reports confirming acts of overt and covert violence by detention staff against adults and children in immigration detention (AHRC, 2019; Commonwealth of Australia, 2017), and this is recorded in the children's drawings dating back to 2002 (Mares et al., 2002; Zwi & Mares, 2015). Unaccompanied children face additional administrative stresses related to age

determination and the threat of deportation to adult facilities, all without adult support (Zwi & Mares, 2015). The damaging impact of this is confirmed in other studies (Ehntholt et al., 2018), raising additional concerns about the duration of children's detention and the lack of independent guardianship and advocacy for unaccompanied minors held in Australian facilites.

Two Canadian papers provide detailed qualitative data and analysis of children's sand tray narratives about life in detention. Thematically this is congruent with findings in the included papers. These authors identify recurring themes in children's play about surveillance and confinement, loss of protection and human violence (Kronick et al., 2015; Kronick et al., 2018). There is similar qualitative detail about daily life in the 1992 report about detention of Vietnamese children in Hong Kong (McCallin, 1992) and detention of Cuban children by the US (Rothe, Castillo-Matos et al., 2002). Confirmatory quantitative data, about rates of adverse exposures such as family separation and deprivations such as interruptions to schooling, are included in recent studies (Hanes et al., 2019; MacLean et al., 2019).

The detention facility is 'home' for the child over the time detained. This is often for months or years for children detained by Australia. It is an environment of high threat, deprivation and dehumanising institutional processes. There are unpredictable but repeated distressing and frightening interpersonal events, including threats to attachment figures. The situation can be likened in some ways to living in a household or community where there is pervasive relational violence (Fowler, Tompsett, Braciszewski, Jacques-Tiura & Baltes, 2009; Vostanis, Tischler, Cumella & Bellerby, 2001). Inside what is the child's only home, repeated traumatic events occur, often in the presence of a preoccupied and helpless parent who cannot be protective. For unaccompanied children there are only other distressed peers for support.

Repeated traumatic exposure like this is understood to generate 'toxic stress'. It follows "strong, frequent, or prolonged activation of the body's stress response systems in the absence of the buffering protection of a supportive, adult relationship" (Shonkoff et al., 2012, p. e326). These experiences result in children experiencing sustained states of arousal and anxiety, with potential neurobiological impacts on their capacity to regulate their emotions and behaviour, increasing irritability, low mood, poor concentration and attention and intolerance of frustration (Teicher & Samson, 2016). Toxic stress, in contrast to positive

or tolerable stressful experiences, is strongly correlated with “later impairments in learning and behavior as well as the roots of chronic, stress-related physical and mental illness” (Shonkoff et al., 2012, p. e326). There is established evidence of neurobiological changes associated with exposure to abuse and neglect in childhood (Teicher & Samson, 2016).

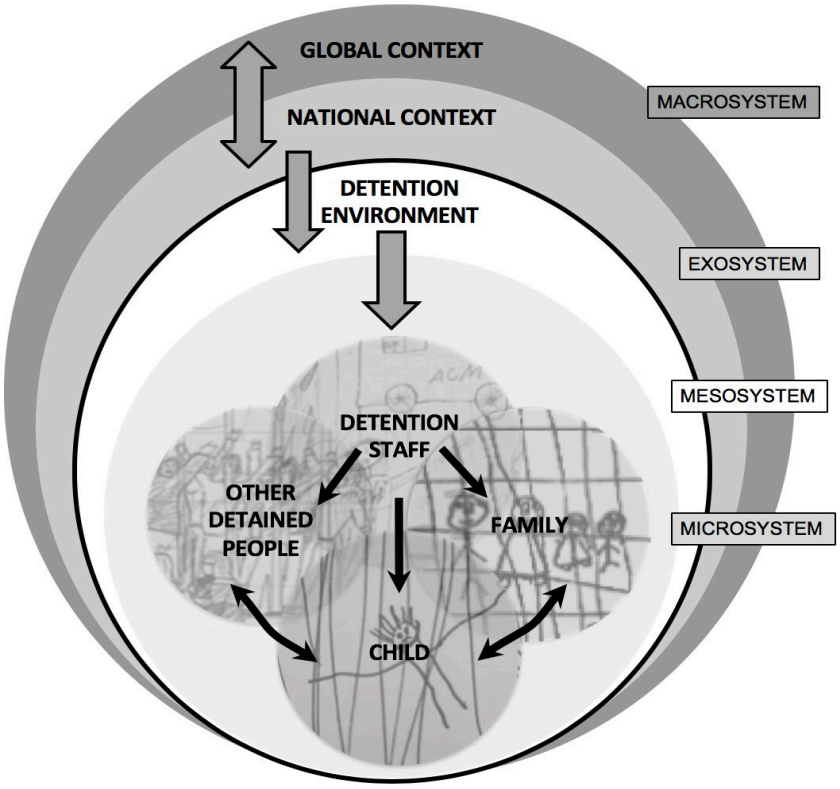
In less adverse contexts there is a continuing process of transaction and adaption between the child, family and wider environments (Sameroff & MacKenzie, 2003). In detention the possibility of reciprocal transactions and influences are limited to those between the child, the family and other detainees, with minimal impact on detention staff and no capacity to influence the detention regime or deterrent policies (Mares et al., 2002; Mares & Zwi, 2015; Zwi & Mares, 2015). The significance of this is that detained children and adults are deprived of agency and choice and that over time, as people become more unwell, interactions between children and the adults they live with contribute to and perpetuate deteriorating mental health.

The interpersonal environment

The child’s immediate context is the ‘microsystem’, “the complex of relations between the developing person and environment in an immediate setting containing that person” (Bronfenbrenner, 1977, p. 514). For detained children, the influence of peers and teachers (Sameroff & MacKenzie, 2003) is replaced by the community of other detained adults and children, and their daily interactions with immigration detention officers.

The proposed schema, outlined below in Figure 8.2, locates the detained child in an ecological context. There are risks and few protective influences in each sphere of the social ecology. Arrows indicates key directions of influence and a lack of transactional reciprocity.

Figure 8.2: Children in immigration detention – adapted ecological schema



Impact of national policies on agency and hope

Hope, or positive expectations about the future, "is predicated on the general belief that despite experiencing stressful situations, one's future will change for the better" (Chang et al., 2018, p. 2). There is conceptual disagreement about what constitutes hope and how it should be measured (Redlich-Amirav, Ansell, Harrison, Norrena & Armijo-Olivo, 2018; Gallagher & Lopez, 2018) but consistent evidence from studies of children and adults indicates that a sense of hope has a strong positive association with psychosocial adjustment, resilience and adaptation after adversity (Cheavens, Michael & Snyder, 2005; Ritschel & Sheppard, 2018). The concepts of optimism, hopefulness and agency are distinct but overlapping. Optimism and hopefulness are generally construed as individual psychological characteristics but are distinct in that both the state and trait of hopefulness include goals, a 'path' or strategic orientation (how the goal will be achieved), and a sense of agency (Snyder, 2000).

Agency has been defined as a person's sense of their ability "to produce and to regulate events in their lives" (Bandura, 1982, p. 122). Bandura identifies a reciprocal and transactional process over time between personal factors (the individual's self-perception and cognitions), their behaviour and the environment (Bandura, 1977). He emphasises that "demoralising conditions can undermine the effective use of well-established skills, leading to reduced capacity and confidence" (Bandura, 1982, p. 142). Both a sense of personal agency and a capacity for planning (described as 'goal' or 'path orientation' in the literature on hope) contribute to resilience, but "Resilience cannot be studied without assessing which features constitute environmentally mediated risk or protection" (Rutter, 2013, p. 476).

There are obvious reality factors that impact on the capacity to be hopeful in persistently adverse circumstances. A qualitative study with refugee children resettled in Canada (Yohani & Larsen, 2009) identified the 'heart of hope' as an internal experience, and the 'sources of hope' as an external experience that includes secure relationships with important people and self-empowering cognitive and physical activities. Displaced and detained children have often been separated from important people, and their relationships are further threatened or changed during detention as adults and children become increasingly unwell. Access to nature and finding meaning in places and in the environment were also identified as supporting hopefulness in this study. Incarceration limits choices about how time is spent, including opportunities for solace in nature (Mares et al., 2002; Mares & Zwi, 2015; Zwi & Mares, 2015).

The studies included here are not longitudinal, but there is an implied chronology. These children had a life before displacement, flight and detention. They and/or their parents imagined a future that seemed safer than the risks associated with staying. This presumably made the losses and uncertainty associated with flight appear worthwhile. Seeking asylum implies a sense of agency as well as hope. Fiske emphasises that, "The state's actions [in detaining asylum seekers] are in response to the agency of refugees [in entering a country to seek asylum]" (Fiske, 2016, p. 10). Immigration detention actively, and in multiple obvious ways, profoundly limits opportunities for personal agency. It is disempowering as there is constant surveillance, a rigid routine and obvious consequences for non-compliance. For children there are few activities that foster competence and success (Cleveland et al., 2018; Coffey et al., 2010).

For many years Australian Government rhetoric has explicitly indicated that current policies have the aim of deterring 'boat people' by removing hope of settlement here (Pickering & Weber, 2014). Many people detained between 2013 and 2018 had left to seek asylum in Australia before the 2013 policy changes were enacted, ruling out resettlement even for those found to be refugees. Children and adults in detention are in a state of protracted uncertainty and fear, a limbo that cannot be described as 'humane'. In our paper reporting on visits during the AHRC inquiry in 2014, we included the words of an unaccompanied boy: "And I don't have even a little hope … and I don't know where my future is?" (Zwi & Mares, 2015, p. 659).

A recent review paper on resilience in refugee children, while acknowledging the diversity of their experience, used an ecological framework to identify factors promoting resilience (Pieloch, McCullough & Marks, 2016). Protective factors included, "social support (from friends and community), sense of belonging (including having positive ethnic identities), valuing education, positive outlooks/optimism, family connectedness, and connection to the home culture" (Pieloch et al., 2016, p. 337). It is not an overstatement to reiterate that all of these elements are repeatedly undermined and/or negated by immigration detention.

The notion of self-efficacy or agency has also been used in studies of parenting quality, and of vulnerability to mental illness. A parent's sense of efficacy directly influences their parenting and has an impact on child adjustment (Coleman & Karraker, 2000; Jones & Prinz, 2005). A sense of efficacy is protective against depression but can be undermined by adversity (Maciejewski, Prigerson & Mazure, 2000).

The literature on hope and agency is relevant to the circumstances and functioning of the children and families included in my studies. They are held in a situation with few opportunities for agency, where the future is anticipated with uncertainty or fear rather than hope. This is as a direct consequence of deterrent policies, including indefinite detention and lack of resettlement options. Reduced agency, loss of hope and pessimism about the future are simultaneously causes and symptoms of depression (Ritschel & Sheppard, 2018). This association has been found in studies of adults held in immigration detention (Cleveland et al., 2018; Coffey et al., 2010). In this setting of threat and enforced passivity, there are few things people can do to influence their daily lives or their futures

apart from what they do to and with their own minds and bodies. Removal of agency and fear or loss of hope about the future are core ingredients in the generation of despair, mental illness and self-harm.

Mental illness

The papers within the thesis have provided evidence that detained parents and accompanied and unaccompanied children suffer high rates of comorbid PTSD, depression and other mental illnesses (Mares & Jureidini, 2004; Mares, 2016b), and this is confirmed in other Australian studies e.g. (Steel et al., 2004) and review papers (Dudley et al., 2012; Hodes, 2010; Newman & Steel, 2008; von Werthern et.al., 2018). Mental illness, developmental delay and regression were identified in 75% to 100% of children in my studies of children detained by Australia (Mares, 2016b; Mares & Jureidini, 2004), rates confirmed by others (Steel, Momartin et al., 2004; Young & Gordon, 2016). This is higher than identified in some international studies (MacLean et al., 2019), but so is average duration of detention by Australia (AHRC, 2019). A recent systematic review found an association in studies of adult detainees between duration of detention and severity of mental health problems (von Werthern et al., 2018). This association was not found in my study of detained children on Christmas Island (Mares, 2016b), suggesting a possible ceiling effect, and, as the review concluded that the association is less consistent in children, suggesting "even small durations of detention are traumatic and harmful for children" (von Werthern et al., 2018, p. 15). One study of adults detained for a mean period of 31 days (a relatively brief period compared to other studies) came to a similar conclusion (Cleveland & Rousseau, 2013).

My research found that children who were detained were significantly more symptomatic than refugee children (presumed to have similar pre-migration risks) who were settled in Australia and not detained (Zwi, Mares et al., 2017). This supports the conclusion (also reached by other studies of children and adults) that the detention experience in itself is pathogenic and acts to compound pre-existing vulnerabilities, playing an independent and exacerbating role in the very high rates of mental illness identified in detained adults and children (Steel, Momartin et al., 2004; von Werthern et al., 2018; Lorek et al., 2009; Coffey et al., 2010; Ehntholt et al., 2018; Cleveland & Rousseau, 2013).

An interesting finding in studies that report data from the SDQ is that, despite being highly symptomatic in other ways, detained children had higher prosocial scores and fewer peer difficulties than are identified in Australian clinical populations (Mares, 2016b; Zwi, Mares et al., 2018). There is a similar finding from a recent large US study which identified that only 2% of 425 detained children, including those with high overall symptom scores, had prosocial difficulties (MacLean et al., 2019). It is possible that, in the crowded and highly stressful environment of immigration detention, where many caregivers are mentally unwell, pro-social skills (consideration, kindness and capacity to share with peers) support coping and survival, particularly when adults have a reduced capacity to meet children's needs. This requires further analysis but highlights the need to better understand the specific and interacting factors associated with psychopathology in detained children. An alternative hypothesis, which remains untested given the restrictions on research with detained children, is that in the situation of prolonged institutionalised neglect and adversity children become less discriminating in their interactions and sociability, akin to a form of attachment disorder (Zeanah, Smyke & Dumitrescu, 2002). This might not be distinguished from enhanced sociability on screening self-report measures such as the SDQ (Zeanah, Chesher, Boris & American Academy of Child & Adolescent Psychiatry Committee on Quality Issues, 2016).

Self-harm and other symptoms of extreme distress

Children are motivated to maintain connectedness, to not be forgotten by their caregivers or other potential protective figures under conditions of threat (Bowlby, 1969). When caregiving is compromised, children are less able to regulate their feelings and behaviours. This can manifest as increased compliance, passivity and withdrawal, behavioural regression, separation or other symptoms of dysregulation (Ryan, O'Farrelly & Ramchandani, 2017; Sangawi, Adams & Reissland, 2015; Van As & Janssens, 2002). Some children externalise distress in provocative attention-seeking and disruptive behaviours, oppositionality, defiance, rudeness and aggression (Mullineaux, Deater-Deckard, Petrill & Thompson, 2009). Comorbidity is common, as confirmed in the included papers (Mares & Jureidini, 2004; Mares, 2016b; Mares & Zwi, 2015; Zwi & Mares, 2015). In extreme situations, profound social withdrawal and refusal of school, self-care, food and water, currently known as 'resignation syndrome', constitutes a medical emergency (Forslund & Johansson, 2013;

Isaacs, 2019; Ngo & Hodes, 2019; Newman, 2019). In individual children, the generation of behavioural problems, mental illness (including suicidal ideation), self-harm and profound withdrawal require expert assessment, and will be influenced by the child's age and family circumstances in combination with traumatic exposures related to displacement and detention.

Self-harm and attempts at suicide are high-risk expressions of extreme distress that increase in children who are traumatised and deprived of other opportunities for expression and agency (Fliege, Lee, Grimm & Klapp, 2009; Dudley, 2003). Anger and protest by children and adults can be productive and appropriate behaviours in relatively safe environments where needs are unmet. In a penal facility such as immigration detention, oppositional or self-harming behaviours increase risk by exacerbating already stressed family relationships, potentially resulting in negative or actual punitive consequences in interactions with detention staff (AHRC, 2019; Commonwealth of Australia, 2017). A recent Government inquiry into offshore detention describes "a deeply troubled asylum seeker and refugee population, and an unsafe living environment – especially for children" (Commonwealth of Australia, 2017, p. v).

The studies in this thesis present vignettes and evidence about frequent thoughts of suicide and acts of self-harm by children in immigration detention (Mares & Jureidini, 2004; Mares et al., 2002; Zwi & Mares, 2015; Mares & Zwi, 2015). Suicidal ideation and self-harm by preadolescent children is very rare in community samples (Morgan et al., 2017), but regularly reported in children in immigration detention (Human Rights Law Centre, 2018). This is discussed in papers by other colleagues and inquiries by human rights bodies (Newman & Steel, 2008; Triggs, 2015; Human Rights Law Centre, 2018), including some I have contributed to (Dudley et al., 2012; Steel, Momartin et al., 2004). A paper on self-harm in adult asylum seekers in Australia identified "exceptionally high rates of self-harm among detained asylum seekers compared to rates in the general Australian population and among asylum seekers in community based settings" (Hedrick, Armstrong, Coffey & Borschmann, 2019, p. 1). The authors note that collection of data on this topic by the Australian Government has not occurred routinely or transparently and that there is no separate data on rates of self-harm in detained children.

When deprived of almost all opportunities for agency and control, it is not surprising that detained people, including children, undertake acts they can control, including on their own bodies – sewing their lips, self-harming, refusing food to the point of starvation, burying themselves alive in makeshift graves, self-immolating, or taking to bed and refusing all that is offered to them. These actions by immigration detainees are most often discussed publicly as either manipulative protest or despair (McIlroy, 2016). Fiske, writing about protests and hunger strikes at Woomera in 2002, suggests that detained adults and children began to "use their bodies to make their voices heard" (Fiske, 2016, p. 124). She suggests that there are many ways to understand detainee hunger strikes and self-harm, as communicative and political acts as well as acts of frustration and despair. Acting and agency are significant here, "a way for asylum seekers to experience a sense of self and some control in their lives" (Fiske, 2016, p. 135).

Parenting and family processes

The accompanied child's daily experience includes the impact of detention on parenting and family relationships. The thesis has provided evidence that family life, parenting capacity and authority are directly and profoundly undermined in the detention environment (Mares & Jureidini, 2004; Mares et al., 2002; Mares & Zwi, 2015). This is supported by other studies of children detained with parents (Kronick et al., 2015, 2018; Lorek et al., 2009). Parental mental illness also alters the quality of parenting and increases adversity for children detained with their parents (Mares & Jureidini, 2004; Steel, Momartin et al., 2004; Mares & Zwi, 2015; Mares, 2016b). In addition to the impact of routine and loss of agency and choice for parents, a recent Government inquiry into offshore detention includes evidence about detention staff intervening in family interactions, disciplining or threatening children, and repeated denigrating and humiliating interactions between staff and children (Commonwealth of Australia, 2017).

There is an increasing literature demonstrating the impact of parental PTSD and depression on parenting in refugee families. Stressors related to forced migration and resettlement increase the risk of harsh parenting and child maltreatment. This is identified in Australian studies (Bryant et al., 2018), international studies with refugee families (Sim, Fazel et al., 2018; van Ee et al., 2016) and systematic reviews (Miles et al., 2019; Timshel et al., 2017). A

recent study of Syrian refugee families modelled the impact of war trauma and displacement stressors on maternal mental health, parenting and child outcomes, finding that maternal distress increased harsh parenting and child rejection, with impacts on children's wellbeing (Sim, Bowes et al., 2018). A related paper emphasised the importance of post-migration support as a way to reduce the stressors that undermine parenting (Sim, Fazel et al., 2018). These papers did not examine the impact of immigration detention on parenting.

In general, having a family is protective for displaced children (Muller et al., 2019), but parental stress and mental illness can change this. There are complex pre- and post-migration factors that contribute to the increased vulnerability of UAM in restrictive settings, as identified in one of the included studies (Zwi & Mares, 2015) and by other authors (Reijneveld et al., 2005; Ehntholt et al., 2018; Hodes et al., 2008). As Fazel and colleagues note, "the experiences of [UAM] and accompanied children are heterogeneous" (Fazel et al., 2012, p. 271).

It is not clear what successful adaptation for individual children or families in the circumstances of prolonged detention would look like. As Frankl has written, "An abnormal reaction to an abnormal situation is normal behavior" (Frankl, 1946/2008). What is clear from my own work and that of others is that, with indefinite detention, the individual and collective capacities of adults and children to adjust and to cope are undermined or overwhelmed, resulting in deteriorating parenting interactions and increasingly severe symptoms for the vast majority of detained children and adults (Mares, 2016b; Mares et al., 2002; Mares & Jureidini, 2004; Mares & Zwi, 2015).

Infants and young children

The wellbeing of infants and young children is rarely included in studies of refugee children despite considerable evidence that quality of parenting and adverse exposure in the early years has a lifelong impact (Appleyard, Egeland, van Dulmen & Sroufe, 2005; Evans, Li & Whipple, 2013; Mares & Woodgate, 2017). Three studies in the thesis, and another of my publications, include a focus on this population (Mares et al., 2002; Mares & Jureidini, 2004; Mares, 2016b; Mares & Powrie, 2008). The findings are consistent with another Australian and two international studies in that a significant majority of detained parents had concerns about the health or development of their infants, with younger children more likely to have

symptoms related to developmental delay and behavioural regression than older children (Kronick et al., 2015; Lorek et al., 2009; Steel, Momartin et al., 2004).

Cumulative adversity over time

The interaction between cumulative risk factors at different times, or in more than one developmental or ecological domain in the generation of psychopathology and mental illness, is complex (Kraemer, Stice, Kazdin, Offord & Kupfer, 2001). There is debate about approaches to modelling vulnerability to PTSD and other psychiatric disorders because refugees have cumulative exposure over time to traumatic war and displacement, followed by stresses related to resettlement. There is some empirical support for a psychological distinction between the experiences leading to displacement and those relating to resettlement; put succinctly, "the causes and consequences of fleeing persecution are fundamentally different psychological phenomena" (Rasmussen et al., 2010, p. 228). This distinction is likely to be less clear for people who experience prolonged post-arrival detention.

The salience of exposure to different kinds of trauma and stress, and the role of various factors as potential 'mediating' or 'moderating' experiences in the generation of symptoms and disorder, is unclear (De Schryver et al., 2015; Miller & Rasmussen, 2010; Neuner, 2010). There is a literature specifically considering the experience of children affected by political violence which includes debate about the timing and targeting of interventions to reduce everyday stressors (designated as psychosocial interventions) versus those addressing traumatic exposures (trauma-focused interventions) (Tol et al., 2010). In the evolution of this discussion, it is acknowledged that the term 'daily stressors' may not adequately reflect the reality that some post-migration experiences can be traumatising in a similar way to direct war exposure (Miller & Rasmussen, 2014).

The findings of my work and Australian studies of detained adults demonstrate that identifying post-migration experiences as 'daily stressors' is entirely inadequate. This terminology goes no way towards encompassing the reality that, in addition to multiple everyday stresses, people held in Australian immigration detention facilities experience ongoing trauma, violence and prolonged uncertainty, often for years. Many examples have been provided. Those detained by other developed countries such as Canada or the UK may

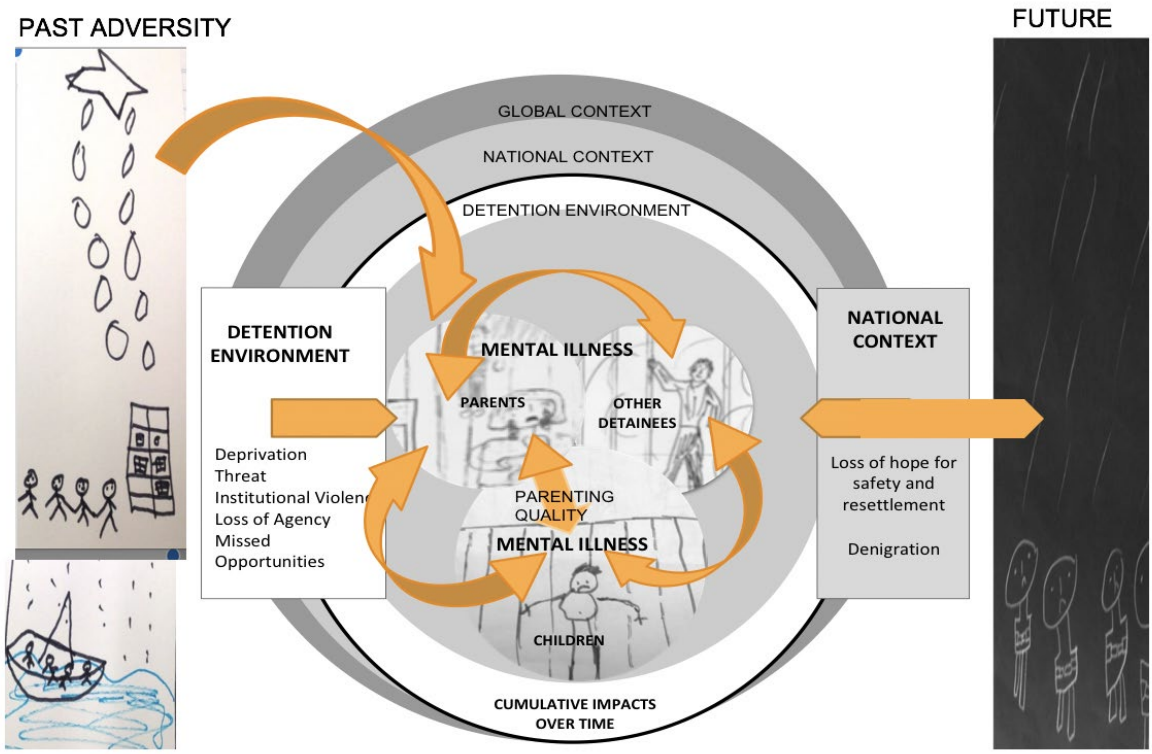
not be exposed to the same levels of self-harm and conflict as is detailed in Australian studies, yet they do face more than 'daily stressors' associated with migration, in the form of continuing uncertainty about visa status, potential and actual family separation, and the threat of deportation. This literature highlights the limitations of linear causality or a simple accumulative approach when attempting to develop explanatory models of risk for children and families exposed to cumulative adversity, including prolonged immigration while seeking asylum.

8.3 An integrated framework

The combined findings of this research, the scoping review and the introduction of ecological and developmental perspectives on risk in childhood support the argument that multiple factors interact in the genesis and perpetuation of high rates of distress and mental illness in detained children, including PTSD, depression, self-harm and 'resignation syndrome'.

Using the evidence provided in the thesis and the conceptual frameworks outlined earlier, it is possible to describe the cascading, transactional interactions between adversities in multiple domains and across time that undermine detained children's wellbeing. Figure 8.1 considers the passage of time, children's developmental imperative, the duration of detention, missed developmental opportunities and continuing exposure to trauma. Deterrent policies have the effect of constricting and removing hope about the future. Figure 8.2 provides an adaptation of the ecological model to demonstrate the risks in each sphere of influence for detained children and includes the limited reciprocity and flexibility in the policy and detention environments. In Figure 8.3, interpersonal interactions in the detention environment itself are highlighted, where ongoing adversity and pervasive mental illness in parents, children and other detainees become self-perpetuating. The role of detention staff is subsumed into the detention environment for reasons of simplification. The dimension of time is reintroduced with the inclusion of prior adverse exposures during displacement and flight, as well as fears about the future. Dimensions of deprivation, threat, dehumanising institutional treatment and chronic exposure to mental illness in parents and other adults have been added to this diagram.

Figure 8.3: An integrated framework for the genesis, aggravation and maintenance of mental illness in children in immigration detention



Considering these factors together, it is clear that children are exposed to multiple and concurrent stressors in each socioecological sphere, and over time, with disruption and loss of family and community and few protective influences. Prior vulnerabilities are aggravated by exposure to trauma, neglect and institutional violence during their detention. Agency and hope are restricted. There is a significant impact on parental mental health and parenting and a forced communality with people with very high levels of mental illness and related acts of self-harm. Immigration detention holds children with existing vulnerabilities in a traumatising environment of high threat and deprivation where multiple factors interact to initiate, aggravate and perpetuate mental illness. The lack of access to independent specialist mental health care is a contributory factor in the perpetuation of mental illness in detained adults and children and a further deprivation during detention. Health service provision and quality is discussed below.

The strengths and limitations of the work and practical and ethical implications of the findings and the proposed framework will now be considered.

8.4 The strengths and limitations of the work

This is a very difficult area to research. The obstacles and associated limitations of the available data were made explicit in Chapter 5 and are evident in both the included papers and the content and process of this thesis. The limitations of the work are consistent with those identified in studies identified in the scoping review (Chapter 4) and systematic review papers (Fazel et al., 2012; Reed et al., 2012; von Werthern et al., 2018). Even when access for the purpose of research to people held in immigration detention is less restricted than it has been in Australia, the international literature includes a predominance of small, cross-sectional studies using mixed methodological approaches. There are few studies with control or matched population groups, and unresolved questions remain about the validity of self-report measures with adults and children from diverse cultural and linguistic backgrounds. The possibility of reporting bias by detained people is acknowledged. These obstacles and the resulting limitations have been acknowledged in the included papers and in the thesis overall.

These limitations do not undermine the significance of the work. Small, cross-sectional studies are useful in defining the nature and extent of a wide range of problems, such as the consequences of immigration detention, and in clarifying areas for future research (Vandenbroucke, 2001; Wadsworth, 2011). Taken together and reviewed systematically, small and mixed methodological studies provide complementary kinds of information, can indicate possible directions and focus areas for future research, and can be used to inform changes in policy and practice.

I suggested in Chapter 5 that the best description of the underlying epistemology is ‘pragmatism’. I used this description because I have done what was possible in the circumstances. Ethics permission and advice was obtained where this was required and possible, and the identity of individual children and adults has been protected. Access to detained children and families was approved for purposes other than research and in the Australian context contact with detained children and families would have been restricted or denied if the primary purpose had been for research. The evidence was gathered opportunistically. Therefore, a strength of the work is that it occurred at all, given the many obstacles. These challenges and limitations are themselves evidence of the particularly

secretive and politicised nature of Australian immigration detention systems. The work has reported on realities that the Australian Government initially tried to deny, then made it a crime to report, then incorporated into the argument for deterrent policies. As identified in the scoping review, there are a small number of studies indicating that permission to undertake research with detained children has been allowed by other countries (Kronick et al., 2015; MacLean et al., 2019; Rothe et al., 2002). Limited access for the purpose of research to adults held in immigration detention facilities has also been enabled elsewhere; see for example Sen et al. (2018) and papers cited in von Werthern et al. (2018).

Newman has written that, "Researching asylum seekers and documenting high rates of suffering and mental health problems, by definition, makes a commentary on systems of detention and health care for this population" (Newman, 2013a, p. 175). The act of undertaking the research and publicising it is therefore inevitably political and politicised. In Australia there have been attempts to undermine the credibility of researchers, and the research findings, and to discourage scrutiny of these policies through access and consent restrictions (Silove & Mares, 2018; Maglen, 2007; Newman, 2013a; Zion, 2013b; Dudley, 2016). Pittaway and Bartolomei argue that research conducted with profoundly disadvantaged groups such as detained asylum seekers could be considered unethical if it does *not* have an advocacy outcome (Pittaway & Bartolomei, 2013); the authors qualify this statement by writing that the power of any resulting advocacy rests on the strength of the research itself. This inevitable nexus between the findings of research into immigration detention systems and advocacy for detained people is contested (Minas, 2004). It is clear that, "From an academic and advocacy perspective, the benefits of rigorous methods in refugee research outweigh the costs" (Jacobsen & Landau, 2003, p. 19).

The opportunistic nature of the included studies raises a question about the influence of sampling and ascertainment bias on the findings. The variety of included studies has been argued to be a strength of the work. The thesis includes convenience samples (Mares, 2016b, Zwi & Mares, 2015), a clinical sample (Mares & Jureidini, 2004), and vignettes based on children and families referred by their legal representatives for medicolegal assessment (Mares, Newman, Dudley & Gale, 2002). The extent to which various approaches to sampling in the included studies may have affected the results is hard to ascertain. There is some corroboration of the findings, in that for example the clinical sample (families referred

to CAMHS) was published alongside a 'population' study of 10 of 11 families from one language group held in another remote IDC. The methodologies differed – clinical assessment versus self-report questionnaires administered by phone – but the rates and severity of mental illness in this 'population' cohort of families was the same or higher on some indices than in the clinic referred group.

The question of perceived or actual bias also needs to be addressed, given the politicised context of the research and the opportunistic nature of the studies. The primary aim has been to present evidence about the impact and consequences of immigration detention for children and parents. There is a potential methodological tension in the work related to positivist notions of truth and an expectation of research 'objectivity' in the medical sciences. This is complemented by the richness added to the data by the inclusion of the voices and experience of detained children and adults (their agency and subjectivity) and the inclusion of reflexive processes. The data has been collected and analysed using a range of methods. It has been understood in the context of 30 years of diverse clinical and academic experience as a child psychiatrist. The work has been undertaken, analysed and published collaboratively, with various colleagues, and in a range of peer reviewed journals or edited books. Many minds have contributed to or reviewed the findings. Reflexivity alone and with peers has been a recurrent element of the process. For these reasons, the argument of systematic bias in the work is difficult to sustain.

Although the individual studies are cross-sectional, the data was obtained using a range of approaches over time (illustrated in Chapter 5, Figure 5.1). As a body of work, it is longitudinal in nature, undertaken between 2002 and 2019, investigating the consequences of Australia's immigration detention of children and families. The convergence of findings from multiple sources provides a richer and more credible understanding of the experience and consequences of immigration detention than a single methodological approach. In their drawings and words, detained children have recorded their perceptions and experiences, and these are included. These are strengths. So also is attention to the impact on immigration detention on infants and parenting and family processes. In 2002 to write about these things was breaking new ground, and since then a body of work has been built on those initial observations.

The thesis includes evidence – gained from recurrent detailed observation and documentation, analysis, collaboration with colleagues and reflection over time – of what would otherwise be a hidden use of public funds for policies and practices that cause demonstrable harm. Writing the thesis has provided an opportunity to reconsider and integrate the original findings into the framework outlined above, illustrating the particularly negative consequences of immigration detention for detained children.

The findings of small, individual studies over time in a particular context can be integrated to strengthen individual findings and to counter potential accusations of bias. The key elements of the pragmatic, longitudinal approach that has been described in the thesis are rigour within contextual limitations, observation and detailed record-keeping, qualitative and quantitative data collection, and iterative cycles of reflection and analysis over time. A reflexive process permeated the work during and after each encounter with detained children and in preparation of each publication. Peer review and consideration of the findings against the extant literature were also key elements. For practical and personal reasons, much of the work was undertaken collaboratively; I consider this a necessity and an additional strength.

The papers published since 2002 and included in the thesis contribute to the accumulating international evidence about the mental health and wellbeing of child and adult asylum seekers who are detained. This is confirmed in a recent systematic review of the impact of immigration detention on mental health that primarily focuses on detained adults (von Werthern et al., 2018) – the review identifies 10 papers on the mental health of children and parents in immigration detention, five of which I have contributed to. Four are included in the thesis (Mares, 2016b; Mares & Jureidini, 2004; Zwi & Mares, 2015; Zwi, Mares et al., 2018) and the other is discussed in the scoping review (Steel, Momartin et al., 2004). The review concludes, in concord with what the thesis papers show, that “profound and far reaching mental health difficulties are found amongst detained children and young people” (von Werthern et al., 2018, p. 15).

In addition, the papers included in the thesis have received 321 citations. More detail on this is provided in Appendix A.

8.5 Human rights, ethics and harm

I have outlined the original contributions and the strengths and acknowledged limitations of this body of work – collected, analysed, reported and reconsidered between 2002 and 2019 – and proposed future research priorities. This section will briefly reconsider some of the human rights and ethical issues that deterrent immigration policies pose, including placing children at increased risk, causing significant harm, and breaching multiple human rights obligations. These issues all have significance for health professionals working in these environments, to be discussed in Section 8.7.

Deterrence as justification

It is reasonably argued that the term 'immigration detention' has the effect of minimising or sanitising what is arbitrary, prolonged incarceration which can in law be indefinite and without crime or sentence (Kalhan, 2010). Penal institutions within Australia's justice system, and the health services provided to inmates, have clear oversight, openness and accountability, and people detained are not held indefinitely. These facts contextualise the practical and ethical implications for clinicians and researchers who are employed in these facilities.

One of the ethical issues raised by mandatory and indefinite immigration detention of asylum seekers is the argument behind the notion of 'humane deterrence', that it is justifiable to knowingly cause harm to one group of people (asylum seekers) in order to benefit or protect others. 'Others' in this case refers both to the Australian community and to people overseas who might undertake a journey here by boat. It is manifestly unethical to mistreat one group of people to achieve a separate objective and would constitute a crime in other jurisdictions. This has been argued in detail in a publication included in the thesis (Mares & Jureidini, 2012) and by others (Mcneill, 2003; Jureidini & Burnside, 2011).

The human, financial and strategic costs of these policies are significant (UNICEF Australia, 2016). Whether indefinite detention and other deterrent policies are effective in reducing 'unauthorised maritime arrivals' is less conclusive. As noted in Chapter 2, 'boat turnbacks' (also criticised on legal and humanitarian grounds) are argued as more likely to be responsible than other deterrent policies for reducing to zero since 2014 the number of

asylum applications made by people who arrive by boat (Spinks, 2018). Deterrent policies, and in particular indefinite mandatory immigration detention, breach human rights, cause demonstrable harm to people and are very costly. Their justification as effective in terms of 'humane deterrence' is not only unethical but also likely to be untrue (Mares & Jureidini, 2012; Rizvi, 2018). Nor have policies aimed at 'stopping the boats' (as the political slogan goes) reduced the number of people seeking asylum in Australia. Since 2014 the number of people arriving by air and seeking asylum has trebled from 8,587 (2014/15) to 27,931 people in 2017/18, and the percentage found to be refugees and granted protection was very low (Rizvi, 2018).

Human rights and child protection

Australia's deterrent policies enact multiple human rights violations, as identified in my papers (Mares, 2016a, 2016b; Mares & Jureidini, 2012) and more fully discussed by elsewhere (Newman, Proctor & Dudley, 2013; Triggs, 2018; AHRC, 2017). For children, detention can never be considered in their best interests (AHRC, 2014; HREOC, 2004; UN, 1990; International Detention Coalition, 2017).

During visits to detention facilities as part of the 2014 AHRC inquiry, we were told that a 'best interests' assessment was carried out by Department of Immigration and Border Protection (DIBP) staff before children were transferred to Nauru. This use of human-rights-based language was doubly deceptive. Indefinite detention is an identified breach of the CRC wherever it occurs. Also, the AHRC inquiry found that the best interests of the child, in the sense intended under the CRC (UN, 1990), had no bearing on whether a child and family were transferred, and that this assessment had never resulted in a child not being transferred to Nauru (Mares, 2016a; AHRC, 2014). This is a significant example of the frequent dissembling and denial by government and detention providers about breaches of human rights associated with current policies. These are detailed more fully in multiple reports about the human rights consequences of mandatory indefinite immigration detention (AHRC, 2017; UNICEF Australia, 2016; Triggs, 2018; Hutchinson & Martin, 2004; Briskman & Mason, 2015; Jureidini & Burnside, 2011).

Another fundamental issue is the lack of systemic governance around child welfare and protection. This has been an ongoing concern, particularly in remote and offshore centres (Layton, 2003; The Guardian, 2016; Commonwealth of Australia, 2017). The lack of an independent guardian or advocate for unaccompanied children was identified 15 years ago (HREOC, 2004; Layton, 2003) and remains a problem (Zwi & Mares, 2015). The Immigration Minister's role as both detainer and guardian constitutes a conflict of interest, resulting in unaccompanied children being at additional risk, unsupported and unrepresented (Crock & Kenny, 2012; Commonwealth of Australia, 2017).

Separation of children and parents

There is a recurrent question about whether separation of children from a parent or parents while the parents are incarcerated for immigration purposes is preferable to detention of children with their families. This possibility was raised by the then Australian immigration minister, Philip Ruddock, in 2004 in response to evidence that detention of children and families was harmful (Steel, Mares et al., 2004). Neither detaining children with parents nor separating them is good. Studies from the US, where separation of children and parents for immigration purposes has increasingly occurred, indicate that PTSD and distress were significantly higher in detained children who had had a period of separation from their mothers than in detained children who had not been separated (MacLean et al., 2019). Other papers identify the negative mental health, developmental and academic impacts of forced family separations for border control and migration purposes, either through deportation or detention, but do not distinguish the impact of detention versus deportation of a parent (Bouza et al., 2018; Lovato et al., 2018; Rojas-Flores, Clements, Hwang Koo & London, 2017). Forcibly separating children from parents for immigration purposes causes harm and should not occur.

Human rights and ethical implications

There is clear evidence, given the harms, costs and contradictions inherent in Australia's current responses to people who seek asylum, that these policies are not ethically or practically sustainable. Developing humane and effective regional responses to the increased numbers of displaced people is undeniably complicated. That said, dismissing the

harms or justifying them in terms of deterrence and 'the greater good', and failure to identify lasting alternatives, is unethical and unproven and suggests exploitation of the suffering of asylum seekers for political gain. It may be an attempt to justify policy failures.

The evidence provide in the thesis confirms that being detained and the detention environment are factors that generate, exacerbate and perpetuate mental illness in adults and children. Reception policies should aim for harm minimisation, and from a public health perspective should focus on prevention and early intervention to reduce further distress and illness while identity and protection claims are assessed. Alternatives include: avoiding 'administrative detention', apart from for the shortest possible time, particularly for children; processing claims fast and efficiently; minimising family separations; supporting reunification; and ensuring that children and adults are supported adequately in practical ways such as with housing, food and access to independent health care and schooling during any interim assessment period – all of which are the opposite of current policy and practice in Australia. These factors add weight to the ethical dilemmas for health professionals working in these settings.

8.6 Health professionals working in immigration detention facilities

The difficulties of providing effective mental health care to people held in immigration detention facilities include: the traumatising detention environment (evidenced in the included papers); the quality and independence of health care, with resulting interference and delays in implementing medical recommendations; and the impact of the work on involved clinicians. These issues were identified specifically in five of the included papers (Mares & Jureidini, 2004; Steel, Mares et al., 2004; Mares, 2016a; Mares & Jureidini, 2012; Silove & Mares, 2018). Since 2012 the literature on this issue has grown considerably (for example: Essex, 2019; Isaacs, 2016; Sanggaran, Haire & Zion, 2016). There are fundamental questions about the professional ethics and wisdom of working within a system which includes abusive practices and where clinical autonomy is undermined. At the same time, people who have sought asylum and been detained are a very vulnerable population who require access to high-quality health care. Discussion of the obstacles to providing effective care to detained people follows.

The traumatising detention environment

The evidence and discussion of the traumatising nature of the detention environment has already been provided, but, to reiterate, during detention in Australian immigration facilities people are repeatedly exposed to adverse and traumatic events and this adds to a cumulative burden of adversity and also undermines the effectiveness of interventions aimed at ameliorating mental illness.

Lack of independent, quality health care, and delays in implementing medical recommendations

Geographical isolation is a challenge for rural and remote health services in much of Australia and in the Pacific (Bourke, Humphreys, Wakerman & Taylor, 2012). It impacts on recruitment, continuity, patient access to specialist expertise, and the need for transfers for emergency, obstetric and specialist elective treatment. This is compounded in remote immigration detention facilities, particularly offshore. Access is one issue; the quality and independence of care is another. In most situations, health care in immigration detention is provided by companies contracted by the Australian Government, currently International Health and Medical Services (IHMS). IHMS staff are subject to restrictive contracts which create a conflict between their professional obligations to their patients and their obligation to their employer (Briskman & Zion, 2014; Essex, 2014). In addition, there is no independent oversight or review body for the health service. On the rare occasion when care was provided by a state-funded Child and Adolescent Mental Health service, independent of DIBP, the Minister and associated politicking, there were still difficulties (Mares & Jureidini, 2004). A range of clinically indicated interventions, including fortnightly therapy and medication, were offered by the expert multidisciplinary team, but with little sustained benefit. This was because the circumstances of indefinite detention continued to exacerbate mental illness, and care was compromised by limited access and because therapeutic recommendations were not subsequently implemented by detention or immigration staff (Mares & Jureidini, 2004).

State coroners charged with investigating deaths of people held in immigration detention have also identified the lack of independence in implementation of medical recommendations as contributory factors in the death of asylum seekers. As an example, the

Queensland State Coroner, reporting on the preventable death of a man held on Manus Island, concluded that systems of health care for detained people needed to 'meet the requisite standard' and required ongoing independent scrutiny. The implication of the report is that, in relation to this man's death, neither was achieved (Coroners Court of Queensland, 2018). More cases are currently under coronial investigation. Recent government and human rights inquiries have also identified inadequate safety and accountability within onshore and offshore detention systems (AHRC, 2019; Commonwealth of Australia, 2017).

Concerns about quality of and access to care, lack of independence, and interference in decision-making about health care provision persisted during my visits to detained children and families between 2002 and 2014 (Mares & Jureidini, 2004; Mares & Zwi, 2015), and were raised by the AHRC inquiries in 2004 and 2014 (AHRC, 2014; HREOC, 2004). The literature on interference with clinical decision-making by non-medical government staff has grown exponentially since 2012, primarily from clinicians previously employed by IHMS (Essex, 2016b; Isaacs, 2016; Sanggaran, Ferguson & Haire, 2014; Young & Gordon, 2016) and health ethicists (Briskman, Zion & Loff, 2010; Briskman & Zion, 2014). There are suggestions that clinicians working in immigration detention systems are inevitably complicit in abusive practices and may be condoning torture (Essex, 2016b; Briskman & Zion, 2014; Dudley, 2016; Newman, 2013b, 2016; Newman et al., 2013; Isaacs, 2016).

In relation to employment by IHMS, it has been bluntly stated that clinicians risk complicity: "by virtue of being involved clinicians facilitate the harm caused by the Australian government" (Essex, 2016a, p. 138). This conclusion is supported by the reality that immigration detention system could not function without clinician involvement. Essex and others examine whether the potential good that clinicians can achieve for detained individuals outweighs the harm they facilitate and legitimise (Essex, 2016a; Briskman, Zion & Loff, 2012). Arguments for a boycott and withdrawal of services from detention facilities is tempered by the reality that any such action would require broad support, including from professional bodies and the organisation of emergency services to ensure detained people were not put at further risk (Essex, 2019; Isaacs, 2015).

If immigration detention of children and adults who arrive by boat and seek asylum is to continue, even for short periods while identity and health checks are undertaken, it is a

priority that health services are contractually independent of the detention service provider. The DIBP should be held to the same standards and subject to the same oversight and scrutiny as medical facilities in Australia's other closed environments, such as prisons, which are staffed by health professionals employed on contracts that do not restrict their professional obligation to act ethically and in the best interests of their patients.

In addition, the DIBP, in whatever incarnation, requires oversight by and advice from an independent body of medical experts, such as recommended by the Palmer Inquiry in 2005. This inquiry was established by the then Minister for Immigration following unlawful immigration detention of Cornelia Rau and subsequent deportation of Vivian Alvarez Solon (Palmer, 2005; Commonwealth Ombudsman, 2005). Both women were missing Australian citizens reportedly suffering mental illness. The Detention Health Advisory Group set up to independently advise the Department of Immigration in 2006 was disbanded in December 2013 (Dudley, 2016).

It has been crucial for clinical experts outside the system to provide independent medical and psychiatric assessment and diagnosis of illness in individuals, and to document the consequences of detention for individuals and families, so that people can receive the care they need. I have first-hand experience of this, dating from 2002 and including assessments of families held on Nauru in 2018. This work has been particularly necessary when acute physical and/or mental deterioration in children and adults has occurred despite multiple consultations with health professionals employed by IHMS. In these circumstances, independent expert evidence has supported legal action so that urgent transfer for specialist treatment in Australia or another country ensures adequate care. Recently it has been increasingly common that transfer from regional processing centres (RPCs) for medical reasons has occurred only after Federal Court intervention, supported by independent medical evidence has resulted in orders for relocation, bringing an end to potentially life-threatening bureaucratic delays (Davidson, 2018b).

As summarised in Chapter 2, in response to the continuing deterioration and crisis in the health of people held offshore, in February 2019, the Australian Parliament passed what is known colloquially as the 'Urgent Medical Treatment Bill' (RCA, 2019b). This legislation aims to ensure that people held on Nauru or Manus Island who require urgent treatment can be

transferred to Australia after assessment and recommendation by two medical practitioners. The Government opposed the passage of the Bill in February 2019 and since re-election in May 2019 continues to obstruct it in the courts and in parliament. Media statements by government ministers continue to vilify asylum seekers (Davidson, 2019b) and also vilify medical practitioners who advocate for their care (Lewis, 2019). How the legislation will be implemented remains divisive and politicised. The wellbeing and medical care of people who have arrived by boat and sought asylum is an issue that is impossible to discuss or address logically or ethically in this political climate. It remains entrenched in party political scaremongering, vilification and deceit.

In summary, the professional duty to put the interests of patients first and to provide care for people regardless of their race, citizenship or visa status arises in a setting where the capacity to meet these obligations is restricted (Briskman & Zion, 2014; Dudley, 2016; Mares & Jureidini, 2004; Steel et al., 2004). This results in significant ethical conflict (Essex, 2019; Sanggaran et.al, 2014). It is a system lacking independent oversight and transparency, where bureaucratic and political decisions undermine the provision of effective clinical care, including in emergencies (Essex, 2014; Briskman et al., 2012). As coronial inquiries attest, this has had tragic and lethal consequences (Coroners Court of Queensland, 2018).

Impact on clinicians

Health care provision in immigration detention occurs in an environment that is violent and traumatising, a situation where potentially inadequate assessment and treatment is provided to adults and children with complex vulnerabilities by contractually restrained or in other ways compromised clinicians. In contrast to most other health settings, it is not only the patients who have little power, but the clinicians themselves. This is because immigration and border protection policies take precedence over state health and child protection legislation, and because there is administrative and political interference in the implementation of medical recommendations. Clinicians in these systems experience compromise and impotence.

This has an inevitable impact, as I and others have documented (Essex, 2019; Mares & Jureidini, 2004; Mares, 2007; Steel et al., 2004). Hearing the stories of significant loss and trauma, feeling powerless to assist, and empathising with their impotence and despair,

increases the risk of vicarious traumatisation (Boscarino, Adams & Figley, 2010). This is akin to but also distinct from work undertaken in environments of significant conflict or humanitarian disaster (Burck & Hughes, 2018; Zwi et al., 2006; Lennon, 2017). This is explored further in Section 8.9 with some thoughts on the experience of 'witnessing'.

There are also risks beyond that of vicarious traumatisation (Silove & Mares, 2018; Steel, Mares et al., 2004). As documented, these include clear efforts to undermine the veracity of research findings and public testimony of medical experts, including psychiatrists (Maglen, 2007), and to threaten, discourage or discredit those who research or speak publicly about these issues (Dudley, 2016; Lewis, 2019). The research is ethically complex (Zion, 2013b) and when, despite the obstacles, evidence has been collected, the researchers have been challenged or denigrated and the findings ignored or justified (Newman, 2013a, 2018; Silove & Mares, 2018). It is complex and potentially traumatising work, and researchers and clinicians require the support of peers and professional bodies if it is to be sustainable (Silove & Mares, 2018, 2019). The risks and opportunities of this work , including in other settings, has been identified (Burck & Hughes, 2018; Dudley, 2016; Lennon, 2017; Newman, 2016). The ethical and professional challenges confirm my experience that clinicians and investigators need to have personal, professional and institutional supports and strategies that emphasis self-care if the work is to be sustainable.

8.7 A place for advocacy

Since the introduction in 1992 of mandatory indefinite detention for asylum seekers, Australian psychiatrists, allied health and medical colleagues have collected and published evidence about the ongoing consequences of Australia's immigration policies (Silove & Mares, 2018). This process includes documenting the mental health and the professional, ethical and human rights concerns raised by this evidence, and is inevitably politicised (Mares & Jureidini, 2012; Newman, 2016).

There is continuing argument about what constitutes appropriate involvement in clinical care, research and advocacy with detained asylum seekers. Although health professionals are registered and practise under various codes of professional and ethical conduct, these do not anticipate or address the situation where people are knowingly harmed by government policy, in direct contradiction to the amount of public spending and the

professional obligations that apply to health professionals, and particularly those with responsibilities for children. This includes mandatory reporting of child risk and maltreatment.

There are pitfalls and contradictions in the respective roles of dispassionate researcher, clinician with specialist expertise, 'witness' to circumstances where children and adults are being harmed, and advocate. There is an argument that advocacy against a system where medical care is compromised is preferable to silence and inaction, or to employment within such systems (Mares & Jureidini, 2012; Newman, 2016; Dawson, Jordens, Macneill & Zion, 2018; Mares, Dudley, Newman, Tennant & Rosen, 2003). This position is contested from several viewpoints. Some professional medical bodies and individual clinicians have taken the position that research or advocacy should be confined to more narrowly conceived areas of professional expertise, with comment restricted, for example, to the quality of health services available to detained asylum seekers, rather than the detention process itself (Bostock, 2009). Another is that politics and political decision-making is complex and that doctors and professional bodies risk losing credibility by venturing into the political fray by speaking in opposition to policies not directly related to health service provision (Bostock, 2009; McAndrew, 2004; Samuell, 2003). Within the bioethical community, the argument has a focus on academic notions of neutrality and the concern that the public authority of the discipline could be lost if "bioethics is used directly in politically contentious debates" (Parker, 2019, p. 1). It is argued that there is a need for "ethics as activism to be clearly separated off from the academic discipline itself and its normative consensus standards" (Ashby & Morrell, 2018, p. 480).

In obvious contrast, other clinicians, public health experts and academics identify the appropriate focus of attention as being the impact of government policies which cause evident harm and breach of human rights (Dawson et al., 2018; Newman, 2016; Silove & Mares, 2018). As is evident in the included papers, I find myself in the latter camp and have undertaken clinical work, advocacy and research from this position (Mares, 2016a; Mares & Jureidini, 2012).

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) and other medical colleges use the CanMEDS framework to identify key professional competencies for medical

professionals (Frank & Danoff, 2007; Royal College of Pysicians & Surgeons of Canada, 2015). The key areas of competency identified in this framework are: Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional (RANZCP, 2012). While all of these roles are relevant when undertaking clinical, research or advocacy with asylum seekers, the advocacy role, based on expertise as a clinician, is in focus here. Competency as a Health Advocate includes "the ability to use expertise and influence to advocate on behalf of patients, their families and carers" and "the ability to understand and apply the principles of prevention, promotion and early intervention to reduce the impact of mental illness" (RANZCP, 2012). Where colleagues and professional bodies have differed is in the scope and nature of this advocacy.

I understand this professional role to carry broad scope and responsibilities, particularly when further harm is occurring to an already vulnerable population, clinical intervention has been ineffective, and prevention and early intervention should be the priority. Psychiatrists constantly work in situations where the domains of mental health, child protection, human rights, law and professional ethics intersect, but perhaps none are so stark or divisive as this (Silove & Mares, 2018). In recognition of the complexities of this setting, the RANZCP and other bodies representing health professionals have developed position statements and practice guidelines in relation to work with asylum seekers and refugees, and specifically with detained populations (RANZCP, 2016, 2017; Royal Australian College of Physicians, 2015).

I have argued that ignorance of what is happening in immigration detention centres is no defence – the human rights violations, distress and illness in children and adults following immigration detention are undeniable. Public health funding and services should be independent and accountable and should prioritise disease prevention and amelioration. For a clinician with child protection obligations, advocacy includes making efforts to remove children from circumstances of risk and harm. In line with professional ethical principles as individuals and as a profession, we have an obligation to prioritise the needs of our patients, including when this includes opposing government policies that undermine health, cause illness and place children at risk (Mares, 2016a; Mares & Jureidini, 2012).

I am not alone in these convictions. Zion has argued that there are compelling reasons why organised advocacy forms part of the ethical duties of a health care clinician working with asylum seekers (Zion, 2013a). Essex considers that clinicians have a role obligation to advance the health of asylum seekers and to uphold human rights (Essex, 2019). I agree. Advocacy for individuals or for groups of people includes collecting and publishing evidence and providing expert testimony and opinion, even when that evidence is repudiated and unwelcome.

It is significant that few children are currently recorded as being detained by Australia (RCA, 2019a). Nonetheless, despite political fluctuations since 2002, the policy of mandatory indefinite detention remains in place, and recommendations by clinicians, researchers and human rights bodies continue to be overtly denigrated, ignored and/or opposed in the Australian court system (Davidson, 2018b; Lewis, 2019; Triggs, 2015). As more countries adopt restrictive responses to people who seek asylum, detaining children and forced separation of children from parents for immigration purposes is increasingly practised, including in the US (MacLean et al., 2019; Teicher, 2018) and some European countries (Hodes et al., 2018). These factors and the accumulated evidence of the harms and human rights violations caused by restrictive immigration practices, including detention and forced family separation, highlight the continuing and international relevance of this body of work.

In Australia, as public opinion has shifted in response to concern about the impact of prolonged detention of adults and children and a lack of realistic resettlement options for people found to be refugees, there have been subtle changes in the political narrative. Nonetheless, individual and collective advocacy has failed to shift policy in any fundamental way. Essex argues that broader social action, including protest, disruption and civil disobedience, is required if there is to be a change in what is bipartisan policy (Essex, 2019). It remains a priority to find ways to increase the effectiveness of communication and translation of these research findings into changes in public attitudes, policy and practice nationally and internationally; this could include more strategic opposition and lobbying. However, I also recognise the difficulties of finding the necessary time and establishing processes for sustained collaboration across academic disciplines, professions and borders so that advocacy efforts based in evidence can be more coordinated and effective.

8.8 Thoughts on being a witness

There are several elements to the notion of witnessing. For example, Peters states that "It is thus a strange but intelligible sentence to say the witness (speech act) of the witness (person) was witnessed (by an audience)" (Peters, 2001, p. 709). A further simplification is helpful; "… witnessing thus has two faces, the passive one of seeing and the active one of saying" (Peters, 2001, p. 709). The related literature primarily concerns passive or accidental exposure to violence in the media or at work, and public actions in response to this, such as court testimony or media statements. The risks of witnessing, apart from more theoretical discussion of what it is and what obligations it entails (Berger, 1980; Sentilles, 2017), are primarily identified as the external consequences of witnessing (sometimes conflated with whistle-blowing), rather than the psychological impact of seeing and saying (Boltanski, 1999; Peters, 2001).

After my first visit to Woomera in 2002 I did not imagine that all these years later I would still be writing and thinking about the detained children families and the many people I have met with over time. Many of the children would now be grown up, and I wonder what happened to them, where they are now. Amid the complexities associated with Australia's response to people who arrive by boat and seek asylum, the motivations for writing the thesis include a mix of political reality and academic and personal imperative. The thesis has provided an opportunity for reflection about the experience of undertaking this work, what I have (passively and actively) witnessed, and what I have done that could be considered as 'witnessing' in the active sense.

In 2002 I wrote with colleagues about our meetings with detained families. Subsequent visits strengthened a sense of responsibility, of being implicated since I had seen and heard things that other people were prevented from knowing about and which, to me, were publicly misrepresented. This 'seeing' (in the sense described above – refer Boltanski, 1999; Peters, 2001; Sentilles, 2017) generated a need to 'do something' in my professional capacity, to act. The publications, research, conference plenaries, expert testimony and other forms of action, including the thesis, are the result. They have also helped to clarify my own position. The public consequences for myself and others of writing and speaking about the topic of this thesis have been discussed (Silove & Mares, 2018).

Detention centres are closed, secretive environments, and clinicians are some of the few 'outsiders' who have consistently and by necessity been allowed in, at times with the threat of criminal charges for speaking out (Dudley, 2016). Initially I was naïve and assumed professional expertise and opinion would be valued, that my colleagues and I could influence policy and practice. It took a while to understand the brutality of the politics (Mares, 2007). Clinical and academic expertise in relation to the consequences of immigration detention has been ignored or denigrated, resulting in feelings of impotence but also anger and fatigue (Mares, 2007). At the same time, concerted government attempts to prevent, silence or undermine medical testimony, including through introduction of the Border Force Act, can be seen as evidence of its potency (Dudley, 2016; Mares, 2016a). It has been said that witnessing "may arguably be the most good that clinicians have achieved in relation to Australian immigration detention" (Essex, 2016a, p. 143). It is true that little would be known about conditions for detained asylum seekers if clinicians had not spoken up. Perhaps this statement is also intended to provide consolation in the face of what could be otherwise be experienced as fatigue and impotence in terms of lasting policy change.

For a psychiatrist there is another aspect to 'witnessing' that is different from 'passively', almost accidentally, seeing atrocities in the media such as described above (Sentilles, 2017). The witnessing as a psychiatrist occurs in person; a choice has been made to go into detention centres, meet, ask questions about trauma, listen to and record the answers, and attempt to understand with the child or adult or family what has happened and what their lives are like. This is an *active* process.

Felman and Laub, writing on the risks of listening to human suffering and traumatic narratives in relation to holocaust testimony, note: "even when the listener … is trained by discipline and by profession to treat trauma and to be its witness, the experience of the witnessing … entails its hazards" (Felman & Laub, 1992, p.xvi). Laub goes on to write that the trained listener has to witness and know about the trauma in such a way that the person who experienced it can also 'know' about it "to partially experience trauma in himself" (Laub, 1992, p. 57). He continues, "… while overlapping to a degree, with the experience of the victim, he … does not become the victim. He preserves his own separate place, position and perspective" (Laub, 1992, p. 58), writing that, for this to be possible, the listener must

also be a witness to themselves. I understand this to refer in part to a capacity for self-reflection.

I am not directly conflating the experience of listening to the stories and witnessing the confinement and distress of detained asylum seekers with holocaust testimony. I am saying that a psychiatrist going inside detention centres to meet with children and adults who are seeking asylum, to experience the circumstances they live in, to ask for and actively hear their stories and to listen in a professional capacity, is in a unique position. It is complex and carries responsibilities. The passive 'seeing' and active 'saying' described by Peters (2001) overlaps with the therapeutic and more personal position of 'hearing and knowing' described by Laub (1992). The child psychiatrist/health professional as witness actively looks, asks, sees and knows. The impetus to act to protect children from harm and in the best interests of their patients is both personal and professional.

In research with Médecins Sans Frontières (MSF) volunteers on the impact and meaning of their fieldwork, Lennon describes the professional role as "a device that allows the personal 'I' to be temporarily sublimated to the objective stance of professional authority and distance, where actions and ethics have protocols and guidelines to support them" (Lennon, 2017, p. 11). She goes on, "As the suffering and uncertainty of a situation increases … so too does the impossibility of trading the personal, ethical response for the simplicity of a role-bounded response" (Lennon, 2017, p. 11). Working in a warzone for MSF is not the same as attempting clinical work or research with asylum seekers detained by Australia, but there are relevant parallels for health professionals who witness suffering that they feel unable to ameliorate. The polarised debate and uncertainty about the appropriate professional and personal responses to detained asylum seekers removes certainty and comfort in the professional role; the position of advocate and 'witness' in this situation is contested and denigrated (Lewis, 2019). Lennon examines the link between empathy, the risk of vicarious traumatisation, and social action. Her research indicates that, "it is the cognitive activity that follows an emotional reaction, which is critical to a comprehensive empathic response, and one that potentially leads to prosocial action" (Lennon, 2017, p. 100). This overlaps with the hazard identified in the clinical situation by Laub, that is, the requirement for the therapist/witness to in a sense to witness to themselves, or risk being traumatised (Felman & Laub, 1992).

There is an element of witnessing, of 'being alongside' another person in many forms of psychotherapeutic work, that is described in different ways in different traditions (Frank, 1971; Wampold, 2015; Dollarhide, Shavers, Baker, Dagg & Taylor, 2012). The notion of 'therapeutic witnessing' has been explored by Papadopoulos in work specifically with refugees (Papadopoulos, 1999, 2018). This 'witnessing together', in Papadopoulos's terms, "enables and empowers individuals, families and communities to re-story and restore themselves by reconnecting with their totality" (Papadopoulos, 2018, p. 34). He writes that in this process the thin or linear narratives associated with trauma and victimhood can be enriched and returned to complexity, freeing up and healing family members. Burck and Hughes, writing about their clinical work in a refugee camp in Calais, France, describe witnessing as "an active process which enables connection with and validation of another person's story" (Burck & Hughes, 2018, p. 228). These authors go on to say, however, that "witnessing and responding at an individual level often seemed completely inadequate when the intolerable conditions remained unchanged" (Burck & Hughes, 2018, p. 100). I understand that feeling.

A parallel between the restorative aspects of therapeutic witnessing at an individual level could be made in relation to advocacy at a systemic level. Public advocacy includes challenging and 're-storying' the linear, dehumanised versions of people who seek asylum that currently dominate media and political discourse. In recent years this 'narrative restoration' has come to include 'self-witnessing' by detained asylum seekers using social media (Rae, Holman & Nethery, 2018) and the verbatim representation of detained people's experience in theatre, fiction and journalism (Boochani, 2017, 2019; Merrick, 2019). These accounts have a particular authority and veracity in an otherwise hostile media landscape dominated by 'thin, linear narratives' and derogatory representations.

8.9 Future priorities

This chapter has integrated the findings from the included papers to propose a framework for understanding the cumulative impact of immigration detention on the mental health of children and parents. The strengths and weaknesses of the research have been identified. In the latter sections I have discussed the implications of the findings for health professionals

who work with asylum seekers, including their role in advocacy, and included reflections on the meaning and experience of 'witnessing' in this context.

Current national and international trends make it likely that Australia and other developed countries will continue to emphasise and invest in deterrent responses to displaced people, including detention. In this circumstance it seems logical that participatory longitudinal studies should be undertaken to identify the factors that support or undermine resettlement of children and adults who arrive, seek asylum and are detained. Approaches to research in this environment have been proposed (Kronick, Cleveland & Rousseau, 2018; Sen et al., 2018).

In Australia, tens of thousands of people who sought asylum by boat and were detained have been identified as refugees. In the past they were given permanent protection. Now they remain on Manus Island or Nauru or are living in the Australian community on temporary visas, often with minimal support. They remain in limbo and with uncertainty about resettlement (RCA, 2019a). Without government permission to undertake research, these people are hard to find and follow up. The Building a New Life in Australia (BNLA) study that follows resettled refugees who were never detained and includes a focus on family process as well as individual outcomes (Lau et al., 2018; Bryant et al., 2018), highlights the enormous disparity in Australia's reception of refugees versus asylum seekers, and also in opportunities to research the impacts of these divergent policies. The captivity of people during detention, and their subsequent monitoring by immigration and border protection officers in the community while protection applications are assessed, means that longitudinal studies, although ethically complex, are possible in a practical and administrative sense.

Governments should support studies to identify best practice – or perhaps, more honestly, 'least worst' practice – in regard to reception policies to enable improved outcomes for refugees *and* asylum seekers, including those experiencing a period of incarceration and prolonged uncertainty about safety and resettlement. A longitudinal comparison of the wellbeing of people arriving by boat who are detained with those who arrive in other ways, including by air, before seeking asylum, could fairly easily be undertaken. This would build on the small local body of work comparing the impact of reception policies that I have

contributed to (Zwi, Mares et al., 2018), as well as international literature that specifically compares the impact of detention in closed facilities with the impact of other reception policies (Ehntholt et al., 2018; Reijneveld et al., 2005). It would also enable testing and evaluation of proposed alternative approaches to reception of asylum seekers (Sampson & Mitchell, 2013; UNHCR, 2014).

In light of Australia's current policy settings, even proposing an approach to researching best practice in immigration detention does feel uncomfortable and potentially unethical (Kronick et al., 2018; Newman, 2013). It is already clear that immigration detention, particularly the indefinite, mandatory, offshore processing approach practised by Australia, is associated with multiple breaches of human rights and a marked deterioration in health and wellbeing of almost everyone who is incarcerated.

Rather than attempting to research or improve current damaging practices, the priority is to identify reception practices that enable 'harm minimisation'. Efforts should be put into research and development of effective and humane regional solutions and viable alternatives to deterrent policies. Using the existing evidence to inform design of, advocacy for and evaluation of alternative approaches to reception and resettlement of displaced people is a priority (Sampson & Mitchell, 2013).

If the inevitability of immigration detention, even for short periods, is accepted, detention providers should allow researchers access for qualitative and quantitative studies within detention settings to determine the least restrictive and least harmful approaches to reception and initial screening of asylum seekers. Ethnographic and participatory studies would provide a more enunciated understanding of the hopes and needs of children and adults who arrive 'unauthorised' and are detained, and the impact of the detention experience and environment. Whatever the process, the findings are likely to be contentious because of the politicised nature of restrictive immigration practices. It is a key priority to find ways to increase the effectiveness of communication and translation of research findings into changes in policy and practice in this and other environments where people, evidence and their representation are strongly contested.

Respecting the agency of adults and children who seek asylum and challenging their narrow representation as either victims or villains (Fiske, 2016) requires participation as a core element of practice when conducting studies in this area. Such studies need to be undertaken without risk to participants or investigators (Silove & Mares, 2018; Newman, 2013a)(R Kronick et al., 2018). There is also a need for multilevel qualitative and quantitative longitudinal and participatory studies to identify effective approaches to intervention once refugee children and families are resettled (Kalfic, Mitchell, Ooi, Schwab & Matosin, 2019; Betancourt & Fazel, 2018; Betancourt, Frounfelker, Mishra, Hussein & Falzarano, 2015; Hodes et al., 2018). This includes people who have been exposed to violence, family separation, and further adversity as a consequence of harsh reception policies.

There is a developing literature on the ethical implications for health professionals of work in immigration detention settings and with asylum seekers more generally (Briskman & Zion, 2014; Essex, 2019; Zion, 2013a). Relevant issues were identified in the papers included in Chapter 7 (Mares & Jureidini, 2012; Silove & Mares, 2018; Steel, Mares et al., 2004) and other publications I have contributed to (Mares & Newman, 2007; Silove & Mares, 2019). The impact on health and other professionals of work with people held in immigration detention could be studied to identify the vicarious costs of current reception policies. This would build on a small but significant literature identifying the individual and organisational resources required to support work with very traumatised and disadvantaged people in highly politicised and conflicted settings (Burck & Hughes, 2018; Lennon, 2017).).

It has been a privilege to hear the stories of adults and children who have sought asylum in Australia, and to receive drawings from children that communicate their experience and their hopes and fears. Without acting on what I had seen and heard, my experience could have been burdensome. Instead, the personal costs of this experience are primarily a consequence of undertaking this clinical work, research and advocacy in what continues to be a profoundly hostile and politicised environment, both for people who seek asylum and for those who advocate for them.

The final chapter concludes the thesis.

Chapter 9: Conclusion

Since 2002 I have made a sustained and original contribution to local and international knowledge about the mental health consequences for families and children who arrive by boat to seek asylum in Australia and are detained. The implications of these policies for health professionals have been discussed. I have authored or co-authored 20 publications on the mental health of this population, 10 of which are included in the thesis

The initial papers were foundational in documenting the effects of Australia's detention polices on children and allowed their experience to be acknowledged in the scholarly evidence and the national discourse. The work overall has confirmed the now undeniable harms caused by indefinite mandatory immigration detention and Australia's deterrent approach to people who seek asylum by boat. It has raised questions about the professional and ethical implications of government policies that knowingly cause harm. The consequences of these policies are now acknowledged by the Australian Government, but this was not the case in 2002. Arguably, the evidence included here has contributed to changes in public and political discourse about the rights, wellbeing and treatment by Australia and other wealthy nations of people who seek refuge through 'irregular migration'.

Although focused on Australia, the work adds to a growing international body of evidence about the ways that reception countries support or undermine the wellbeing of child refugees and asylum seekers, with immigration detention confirmed as an extremely adverse experience. These are issues of great salience globally as the number of people displaced and seeking asylum has more than trebled from 20 million to over 70 million between 2002 and 2019.

The information in the included papers, and the thesis more generally, is used regularly at home and internationally by researchers, medical and human rights bodies, lawyers and advocates to inform policy and position statements, and to respond to the needs of people who have been detained. The evidence that my colleagues and I have published since 2002 has been acknowledged and denigrated by the Australian Government, providing a kind of inverse recognition of its salience and potency.

This is a highly politicised area of study, and the findings cannot help but be contentious. The thesis has grappled with significant challenges associated with undertaking research in this context. There are inevitable limitations in the data, evidence in themselves of the closed and secretive circumstances within which asylum seekers are detained. The included papers, and the thesis as a whole, document the persistence and collaboration involved in this research. My intention has been to do what was possible and justifiable in the circumstances while protecting the individual identities of adults and children.

Despite the difficulties, over time and with co-authors I have documented and integrated evidence of different kinds and from diverse sources that sheds light on the impacts and consequences of Australia's restrictive reception policies for people seeking asylum. The findings are clear and consistent and have international salience: immigration detention is associated with very high levels of distress and mental illness in adults and children and multiple breaches of human rights. There are higher levels of psychopathology in children and adults detained by Australia than identified in most international studies. The Australian Government detains people who seek asylum for longer on average than elsewhere, and the mental health of adults is shown to deteriorate with time detained. This association is less clear in children for whom any period of detention has adverse consequences.

Children in immigration detention face cumulative threats to their wellbeing in each socioecological domain. The impact of global factors, including growing numbers of people displaced, deterrent reception policies, and the detention environment, all have an impact on parental mental health and on parenting, as well as on children themselves. There are few protective factors and a cumulative negative impact on wellbeing. Health and mental health care in this setting is not independent or likely to be effective in an environment where children remain unsafe and exposed to continuing deprivation and threat.

From the first paper in 2002, my work has consistently included attention to areas of significance that are frequently overlooked or under-reported. A developmental and relational focus has been maintained throughout by identifying the impact of immigration detention on infants and pre-verbal children, and on parenting and family processes. The experience of detained children is included as directly as possible through their words and

drawings. This privileges their agency and subjectivity and their role as witnesses, rather than solely as subjects or 'victims' of either immigration policies or the research process.

Writing the thesis has provided opportunities for integration and reflection. It has resulted in an extension of the original findings, including developing an integrated framework for appreciating the cumulative negative impacts of immigration detention on children's wellbeing. The practical and ethical implications for health professionals and researchers have been reconsidered and I have had the opportunity to reflect on the experience of being a witness as part of undertaking this work. As the papers attest, at each contact with detained people I have attempted to include their experience, to document and interrogate my reactions to what I have seen, felt and understood, to debrief with colleagues, and to grapple with the resulting tensions between objective observer, health professional and implicated participant. When considered overall, the work offers an innovative approach to undertaking research in uncertain and divisive contexts.

Primarily the hope must be that the evidence presented here will inform more effective responses to the increasing numbers of displaced people globally. Given the evidence that even brief periods of immigration detention are damaging for children, I look forward to governments in Australia and around the world giving priority to finding better ways to support displaced people during flight, transition and resettlement. There is a need for longitudinal participatory studies to identify the best ways to mitigate the effects of trauma associated with this process. While immigration detention continues, citizens are entitled and governments have an obligation to provide access to evidence about the impacts of harsh and discriminatory immigration and border protection policies, and their costs and benefits. Equally important is to ensure that health services for people who are detained while seeking asylum are independent and can be effective.

Future research requires transdisciplinary and international collaboration to develop effective and humane regional solutions and viable alternatives to current harmful reception policies for people who seek asylum in wealthy nations such as Australia. Longitudinal and participatory studies with people now in the community who have sought asylum will ensure the findings are informed by their perspective and experience. It is a priority to find ways to

increase the effectiveness of communication and translation of research findings, in this context and similarly politicised contexts, into changes in policy and practice.

The work that informs this thesis has been driven by two kinds of narrative or imperative. The first is the stories I have heard from people who have fled their homes to seek refuge, and instead have been incarcerated and denied safety and resettlement by the government of the wealthy country that is my home. The second is the translation of what I have seen and heard during visits to immigration detention facilities into evidence, so as to change the story Australians and others in wealthy reception countries are told every day – that these people are undeserving, a threat and not like 'us', and that to harm them is justifiable. My hope is that the evidence included here leads to more humanity and generosity in our response to people who seek asylum, that protection claims are processed fast, that money is not wasted on causing further harm, and that people are supported to settle and participate fully in Australian's rich multicultural life.

Appendices

Appendix A: Chronological list of publications about refugees and asylum seekers

Papers highlighted in blue are included in the thesis

1. Mares, S., Newman, L., Dudley, M. & Gale, F. (2002). Seeking refuge, losing hope: Parents and children in immigration detention. *Australasian Psychiatry, 10*(2), 91-96.

2. Mares, S., Dudley, M., Newman, L., Tennant, C. & Rosen, A. (2003). Politics of children or childish politics? *Australasian Psychiatry, 11*(4), 477-477.

3. Mares, S. & Jureidini, J. (2004). Psychiatric assessment of children and families in immigration detention: Clinical, administrative and ethical issues. *Australian & New Zealand Journal of Public Health, 28*(6), 16-22.

4. Steel, Z., Momartin, S., Bateman, C., Hafshejani, A., Silove, D., Everson, N., Salehi, J. K., Roy, K., Dudley, M., Newman, L., Blick, B., Mares. S., Raman, S. & Everett (2004). Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia. *Australian & New Zealand Journal of Public Health, 28*(6), 23-32.

5. Steel, Z., Mares, S., Newman, L., Blick, B. & Dudley, M. (2004). The politics of asylum and immigration detention: Advocacy, ethics, and the role of the therapist. In J. P. Wilson & B. Drozdek (Eds) *Broken Spirits: The Treatment of Traumatized Asylum Seekers, Refugees, War and Torture Victims* (pp. 659-687). New York: Brunner-Routledge.

6. Mares, S. (2007). First do no harm. In S. Mares & L. Newman (Eds) *Acting from the Heart: Australian Advocates for Asylum Seekers Tell Their Stories* (pp. 217-222). Sydney: Finch Publishing.

7. Mares, S. & Newman, L. (Eds) (2007) *Acting from the Heart: Australian Advocates for Asylum Seekers Tell Their Stories.* Sydney: Finch Publishing.

8. Mares, S. & Powrie, R. (2008) Infants in refugee and asylum seeker families. In A. Sved-Williams & V. Cowling (Eds) *Infants of Parents with Mental Illness: Developmental, Clinical, Cultural and Personal Perspectives* (pp 141- 157). Queensland: Australian Academic Press.

9. Dudley, M., Steel, Z., Mares, S. & Newman, L. (2012). Children and young people in immigration detention. *Current Opinion in Psychiatry, 25*(4), 285-292.

10. Mares, S. & Jureidini. J. (2012) Child and adolescent refugees and asylum seekers: The ethics of exposing children to suffering to achieve social outcomes. In M. Dudley, D. Silove F. & Gale (Eds) *Mental Health and Human Rights* (pp. 403-414). Oxford: Oxford University Press.

11. Zwi, K. & Mares, S. (2014). (Invited commentary) Reducing further harm to asylum seeking children: The global human rights context. *International Journal of Epidemiology 43*:1, 104-106.

12. Mares, S. & Zwi, K. (2015) Sadness and fear: The experiences of children and families in remote Australian immigration detention. *Journal of Paediatrics & Child Health. 51*(7), 663-669.

13. Zwi, K. & Mares, S. (2015) Stories from unaccompanied children in immigration detention: A composite account. *Journal of Paediatrics & Child Health. 51*(7), 658-662.

14. Mares, S. (2016) Fifteen years of detaining children who seek asylum in Australia – evidence and consequences. *Australasian Psychiatry, 24*(1), 11–14.

15. Mares, S. (2016) The mental health of children and parents detained on Christmas Island: Secondary analysis of an Australian Human Rights Commission data set. *Health & Human Rights: An International Journal, 18*(2), 219-232.

16. Ratnamohan, L., Mares, S. & Silove, D. (2018). Ghosts, tigers and landmines in the nursery: Attachment narratives of loss in Tamil refugee children with dead or missing fathers. *Clinical Child Psychology and Psychiatry*, *23*(2), 294-310.

17. Zwi, K., Mares, S., Nathanson, D., Tay, A. K. & Silove, D. (2018). The impact of detention on the social–emotional wellbeing of children seeking asylum: A comparison with community-based children. *European Child & Adolescent Psychiatry, 27*(4), 411-422.

18. Zwi, K., Woodland, L., Mares, S., Rungan, S., Palasanthiran, P., Williams, K. ... & Jaffe, A. (2018). Helping refugee children thrive: What we know and where to next. *Archives of Disease in Childhood, 103*(6), 529-532.

19. Silove, D. & Mares, S. (2018) Editorial: The mental health of asylum seekers in Australia and the role of psychiatrists. *BJPsych International*, *15*(3), 65-68.

20. Silove, D. & Mares, S. (2019) The mental health of refugees and people who seek asylum. In R. Benjamin, J. Haliburn & S. King (Eds) *Humanising Mental Health Care in Australia: A Guide to Trauma-informed Approaches* (pp. 143-155). Routledge.

Appendix B: Data collection

Dates	Immigration Detention Centres (IDC/APOD)[1]	IDC Visits	Role	Number of families/reports	Purpose
January 2002	Woomera IDC, northern South Australia (SA)	1	Medicolegal reports	3 families 5 adults + 6 children 3 reports	Psychiatric assessment of families and children
July-August 2002	Woomera IDC, SA	2	Employed by SA CAMHS[2]	11 families 0 reports (CAMHS)	Psychiatric assessments and intervention with asylum seeking families and children held in detention
2003	Baxter IDC & APOD, SA	2	Medicolegal report	1 family 2 adults + 2 children 1 report	Psychiatric assessment of families and children held in immigration detention
2003 -2006	Villawood IDC, Sydney, NSW	4	Medicolegal reports	2 families 6 reports	Psychiatric assessment of families and children held in immigration detention

[1] IDC/APOD – Immigration Detention Centre/Alternative Place of Detention

[2] CAMHS – Child and Adolescent Mental Health Service

Dates	Immigration Detention Centres (IDC/APOD)[1]	IDC Visits	Role	Number of families/reports	Purpose
2005-2009	Sydney		Therapy and report 10 visits in the community	1 child 1 report	Child in community in the care of Department of Community Services
2009/10	Sydney		Medicolegal report 2 visits in the community	1 child 1 report	Child in community previously detained
August 2012	Darwin Airport Lodge IDC, Darwin, NT	4	Medicolegal reports	5 UAM[1] 5 reports	Psychiatric assessments of unaccompanied children held in immigration detention
1st -8th March 2014	Christmas Island (CI) APODs – Construction Camp, Aqua, Lilac and Charlie Compounds	7 days	RANZCP[2] consultant to the AHRC[3] Inquiry into Children in Immigration Detention		Extensive access to detained families and children Semi-structured interviews with 230 people in family, language and cultural groups including UAM DIBP[1] staff not present at meetings with detained families Meetings with DIBP, Serco,[2] IHMS[3] and IHMS Mental Health team, support services and AFP[4] representatives.

[1] UAM – Unaccompanied minors

[2] RANZCP – Royal Australian & New Zealand College of Psychiatrists

[3] AHRC – Australian Human Rights Commission

Dates	Immigration Detention Centres (IDC/APOD)[1]	IDC Visits	Role	Number of families/reports	Purpose
April 2014	Blayden and Wickham Point APOD facilities, Darwin, NT	2 days	RANZCP consultant to AHRC Inquiry as above		As above
July 2014	Christmas Island APOD	2	Medicolegal reports	7 UAM 7 Reports	Psychiatric assessment of children
August 2014	Wickham Point APOD, Darwin, NT	1	Medicolegal report	1 family (2 adults+ 2 children) 1 Report	Psychiatric assessment of children and families
February 2017	Community		Medicolegal report Home visit	1 family (2 adults+ 2 children) 1 Report	Psychiatric assessment of child and family

[1] DIBP – Department of Immigration and Border Protection

[2] Serco – Detention service provider

[3] IHMS – International Health and Medical Services, contracted health service provider

[4] AFP – Australian Federal Police

Dates	Immigration Detention Centres (IDC/APOD)[1]	IDC Visits	Role	Number of families/reports	Purpose
July -Aug 2018	Nauru		2 medicolegal reports & supervision of 3 others Teleconference and medical notes	2 families (2 adults+ 3 children) 2 Reports	Expert opinion on 6 other psychiatric reports of child detained for 5 years Expert report on mother and adolescent son detained 5 years
TOTALS	10 facilities at 6 locations	25 days		28 medicolegal reports	

Notes

Between 2002 and 2014 there were changes in the name of the Australian Government Department responsible for immigration, the companies contracted to run immigration detention services and to provide health services to detained adults and children. In 2002, the department was called the Department of Immigration, Multi-cultural and Indigenous Affairs (DIMIA)[1] and at that time the centres were run by Australian Correctional Management (ACM), a subsidiary of the American Wackenhut Corporation. Medical and allied health staff were employed by ACM to work in the ACM Medical Centres. In 2014, the department was renamed the Department of Immigration and Border Protection (DIBP) and Serco was the multinational corporation running detention facilities. Health Services were then contracted to International Health and Medical Service (IHMS), with Maximus contracted as the non-governmental organisation providing activities for unaccompanied children. On 20 December 2017, the Australian Border Force (ABF) and all former DIBP activities were incorporated into the Department of Home Affairs (DHA).

1 DIMIA – Department of Immigration, Multi- cultural and Indigenous Affairs

Appendix C: Major legislative/policy changes and key events since 1992

Year	Change and Implications	
1992	Introduction of mandatory detention for all people arrive in Australia by boat to seek asylum with a time limit of 273 days on period of detention; this time limit was removed in 1994.	
2001	War against the Taliban in Afghanistan by US-led coalition	
	(August) MV *Tampa* – Norwegian freighter rescued 433 asylum seekers – refused entry to Australian waters	Refugees on the MV *Tampa* were accepted by New Zealand and Nauru
	The Pacific Solution	Christmas Island and other northern islands excised from Australia's migration zone; boat arrivals returned to Indonesia or processed on Christmas Island
2004	HREOC National Inquiry into Children in Immigration Detention Jan 1999 – Dec 2003 HREOC Report published	
2005	*Migration Amendment (Detention Arrangements) Act 2005*	s197AB – Residence Determination
		s195A – Bridging Visa E provided lawful status to reside in the community whilst their immigration status was resolved
		S4AA – A measure of Last Resort Affirmed the principle a that "a minor shall only be detained as a measure of last resort"
1999-2008	Temporary protection visas (TPVs) introduced	Protection for three years, after which those found to be refugees had to reapply
2008	New Directions in Detention policy, TPVs ceased	Closure of Manus Island and Nauru detention centres

Year	Change and Implications	
2010	Bridging visa E introduced	Gave limited rights to live in the community to people awaiting processing of refugee claims
2012	Manus Island and Nauru processing centres reopened as numbers of people arriving by boat to seek asylum increased	
Jul 2013	Offshore processing reintroduced	After 19 July 2013 anyone arriving by boat was subject to offshore processing and transferred to processing centres on Nauru and Manus Island; even if found to be a refugee, they will never be resettled in Australia
Sep 2013	Excision of the whole of Australian from the migration zone for unauthorised people arriving by boat Operation Sovereign Borders	Asylum seekers who arrive anywhere in Australia by boat could not apply for a visa except at the discretion of the Minister for Immigration; this resulted in large numbers of people with unprocessed claims
Oct 2013	Terminology changed from 'irregular maritime arrivals' to 'illegal maritime arrivals'	
2013-2015	Refugee Status Determination (RSD) was suspended	Burden of proof shifted to the asylum seeker and reference to the Refugee Conventions removed from Australia's migration legislation; created new ground to deny protection visas to people under some circumstances
2014	AHRC Inquiry into Children in Immigration Detention Inquiry and Report	
2015	TPVs reintroduced	Protection claims reassessed after three years but no pathway to citizenship

Year	Change and Implications	
2012-2018	Humanitarian Resettlement Program	Increases in numbers settled under the program from 13,750 to 20,000 then reduced again in September 2013; numbers will increase to 18,750 places in 2018-19. Sep 2015 – additional 12,000 places offered to refugees from Syria and Iraq
July 2015	*Australian Border Force Act*	Secrecy provisions made it a crime punishable by up to two years for an 'entrusted person' to make a record of or disclose protected information Amended in October 2016 and August 2017 to except doctors, nurses and other health professionals
Nov 2016	Resettlement deal with the US	Refugees on Manus Island and Nauru could be eligible for resettlement in the US; a small number were resettled in 2017
April 2016	PNG Supreme Court declares that Australia's transfer and detention of asylum seekers on Manus Island is illegal	Manus Island centres close on 31 October 2017
October 2018	Adult and child detainees gradually moved to Nauru or to Australia for medical treatment.	Christmas Island Detention Centre closes
December 2018	Most children and families transferred from Nauru to Australia or resettled in the US	Single adults remain on Nauru and Manus
Feb 2019 June 2019	Australian Parliament passes the Urgent Medical Treatment Bill despite government opposition Implementation remains divisive	The Bill allows people held on Manus Island or Nauru to be transferred to Australia for urgent medical treatment if this is recommended by two medical practitioners; despite opposition, government implementation of the Bill includes the reopening of detention facilities on Christmas Island

Additional sources

Australian Human Rights Commission. (2014). *The Forgotten Children: National Inquiry into Children in Immigration*, www.humanrights.gov.au/our-work/asylum-seekers-and-refugees/publications/forgotten-children-national-inquiry-children

Human Rights and Equal Opportunity Commission. (2004). *A Last Resort? National Enquiry into Children in Immigration Detention*, www.humanrights.gov.au/sites/default/files/document/publication/alr_complete.pdf

Refugee Council of Australia. (2017). *Recent Changes in Australian Refugee Policy*, www.refugeecouncil.org.au/recent-changes-australian-refugee-policy/

Special Broadcasting Service. (2013). Timeline: Australia's Immigration Policy, www.sbs.com.au/news/timeline-australia-s-immigration-policy

Appendix D: Scoping review – additional data

For the scoping review I used the five-stage framework for undertaking a scoping review first outlined by Arksey and O'Malley (2005) and enhanced by Levac and colleagues in 2010 (Levac, Colquhoun & O'Brien, 2010; Peters et al., 2017). Stages 1–4 are considered, as well as part of Stage 5. The implications for practice are addressed in Chapter 8.

Stages of scoping review

1. Identify the research question and the purpose of the review.
2. Find the relevant studies, balancing feasibility with comprehensiveness.
3. Select the studies using an iterative approach and extract the data.
4. Chart the data and consider incorporating a numerical summary and qualitative thematic analysis.
5. Collate, summarise and report the results, including identifying the implications for policy, practice and research.

A PRISMA Extension for Scoping Reviews was recently published in order to improve the reporting of scoping reviews (Tricco et al., 2018).

The objectives, inclusion criteria and methods were specified in advance. The research question and purpose of the review are as outlined above.

With the invaluable assistance of Leila Mohammadi, Flinders University Research Librarian, the relevant studies and publications were identified through a search of the Medline, PsychINFO, Emcare, CINAHL and Scopus databases for the period from 1 January 1992 to 30 July 2018. An example of the database search strategy and list of search terms for Medline and Psychinfo is included in Figure D.1.

This time period was selected because the *Migration Reform Act 1992*, requiring and enabling mandatory indefinite detention of asylum seekers arriving without authority, was passed in 1992. The end date, 31 May 2019 was within the timeframe of the thesis. The process was repeated in late May 2019. Search terms and categories included those relating to mental health and disorder, children, parents and parenting and families, child

development, and asylum seekers and refugees. The results of both stages of the search are shown in Table D.1.

Table D.1: Full scoping review process July 2018 and May 2019

Search process	**No. of papers – initial search**	**Update 1 Aug 2018 – 31 May 2019**	**Total number of papers**
1. Identify research question and purpose			
2. Find relevant studies			
Database:			
Medline	48	11	59
PsychINFO	770	87	857
Emcare	1281	419	1700
CINHL	721	77	798
Scopus	1741	152	1893
Total	4,557	746	5303
3. Select studies using an iterative approach			
Duplicates	-3549	648	4197
Initial review of title and abstract; excluded because not about refugees or asylum seekers	1008 -902	98 -77	1106 -979
Retained for full text review	106	21	127
Extra pap during review process	+ 7	+2	+9
Full text or abstract review when full text unavailable	113	23	136
Systematic review, review and commentary papers	10	4	14
Review and commentary papers re immigration	11	5	16

detention of children			
Post-migration stressors or interventions, children and families (not detained)	26	8	34
Interventions with refugee children and families	36	14	50
Data re detained children and families	20 for full text review (– 6 of mine in thesis) = 14	2	22 (-6)
Outcome	14	2	16
4. Chart and analyse the data from 16 papers			

From the initial search 4,557 references were imported into Endnote and 3,549 duplicates were removed, leaving 1,008 papers. An iterative process enabled the 4,557 papers identified in the initial search to be reduced to 113 papers, which were retained for further review. The search was updated in May 2019 and the iterative process was repeated. Nine additional papers were identified in the process of the review, meaning that in all a total of 136 papers were full text or abstract reviewed. Fourteen of these were systematic reviews about the mental health of refugee children (see Table D.2). Sixteen were review or commentary papers about the impacts of immigration detention on children (see Table D.3), and a further 34 papers reported studies on post-migration stressors that did not include detention (see Table D.4). Another 50 papers were primarily about interventions with displaced children and families and have not been tabulated. These provide useful contextual data but have been excluded from the final scoping review results. Selection criteria for the included papers are listed in Chapter 4. Also see Chapter 4 for a full discussion of the scoping review findings and discussion of the 22 papers for full text review. Six papers that I authored or co-authored which are included in the thesis were identified in the process and excluded from full discussion in Chapter 4, leaving 16 papers for discussion.

Figure D.1: Search strategy

Database(s): Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily, Ovid MEDLINE and Versions(R) 1946 to April 11

2018

Search Strategy:

#	Searches	Results
1	mental disorders/ or adjustment disorders/ or Anxiety/ or exp anxiety disorders/ or anxiety, separation/ or affective symptoms/ or exp aggression/ or exp dissociative disorders/ or delusions/ or exp "schizophrenia and disorders with psychotic features"/ or schizophrenic language/ or paranoid behavior/ or exp eating disorders/ or exp factitious disorders/ or exp impulse control disorders/ or exp "attention deficit and disruptive behavior disorders"/ or child behavior disorders/ or child reactive disorders/ or exp mood disorders/ or depression/ or neurotic disorders/ or exp personality disorders/ or exp "sexual and gender disorders"/ or exp somatoform disorders/ or psychoses, substance-induced/ or exp Self-Injurious Behavior/ or dangerous behavior/ or exp impulsive behavior/ or depersonalization/ or exp obsessive behavior/	724979
2	Mental Health/ or Resilience, Psychological/ or happiness/ or hope/ or laughter/ or love/ or pleasure/ or self concept/ or self efficacy/ or Empathy/	124452
3	exp Mental Health Services/	87354
4	(wellness or wellbeing or well being or positive psych* or resilien* or flourish* or languish* or optimis* or eudamonic or hedonic or resilien* or positivism* or protective factor* or happy or happiness or pleasur* or positive emotion* or positive affect* or life satisfaction or self accept* or personal growth or autonomy or positive relations* or psychological endurance or mental endurance or affection or enthusias* or gratitude or grateful* or love or pride or sympath* or empath* or hope*).tw,kw.	433446
5	(Mental health* or mental illness* or mental disorder* or mentally ill or behavio?ral health or abnormal psych* or depression or depressive or mood disorder* or personality disorder* or psychiatr* or schizophreni* or bipolar or compulsive* or obsessive* or impulsiv* or self injur* or self harm* or suicid* or psychotic or abnormal psych* or phobi* or psychos* or resilien* or anxiety or anxious or stress* or trauma or fear* or sad*).tw,kw.	1822701
6	1 or 2 or 3 or 4 or 5	2451879
7	Refugees/	8517
8	(refugees or "asylum seek*" or "humanitarian migrant*").tw,kw.	6944
9	7 or 8	10867
10	human development/ or adolescent development/ or child development/ or language development/ or child language/ or crying/ or mental competency/ or neurobehavioral manifestations/ or psychology, social/	72343
11	Motor Skills/	22167
12	Language Development Disorders/	5801
13	("child develop*" or "cognitive develop*" or "physical develop*" or "language develop*" or "speech develop*" or "social develop*" or "emotional develop*" or "academic performance" or	32179

	"school performance").tw,kw.	
14	family conflict/ or parent-child relations/ or father-child relations/ or mother-child relations/ or parenting/	60505
15	("family relation*" or "child* relation*" or attachment or "parental loss" or "parent-child seperat*" or "parent child seperat*" or bereavement or family or families).tw,kw.	924986
16	10 or 11 or 12 or 13	120058
17	14 or 15	964252
18	6 or 16	2542765
19	9 and 16 and 18	105
20	9 and 18	3706
21	adolescent/ or child/	2580327
22	(infant* or toddler* or preschool* or pre-school* or child* or adolesc* or teenag*).tw,kw.	1670426
23	21 or 22	3329729
24	20 and 23	1506
25	limit 24 to (english language and yr="1992 -Current")	1239
26	detention.mp.	2603
27	25 and 26	48
28	(Seeking refuge, losing hope: parents and children in immigration detention).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	0
29	Acting from the heart Australian advocates for asylum seekers tell their stories.m_titl.	0
30	(Infants in refugee and asylum-seeker families Infants of Parents with Mental Illness).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	0
31	(Sadness and fear: The experiences of children and families in remote Australian immigration detention).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	1

32	25 and 31	1
33	27 and 31	1

Table D.2: Systematic review and review papers – mental health/wellbeing of displaced/resettled children and families

Citation	Reference	Year	Nature of paper	Comments
(Miles et al., 2019)	Miles, E. M., Narayan, A. J. & Watamura, S. E. (2019). Syrian caregivers in peri-migration: A systematic review from an ecological systems perspective. *Translational Issues in Psychological Science, 5*(1), 78-90.	2019	A systematic review using an ecological systems perspective.	Application of ecological framework to analysis of peri-migration stressors for Syrian families. Includes impact on caregivers and parenting.
(Hodes et al., 2018)	Hodes, M., Melisa Mendoza, V., Anagnostopoulos, D., Triantafyllou, K., Abdelhady, D., Weiss, K. ... & Skokauskas, N. (2018). Refugees in Europe: National overviews from key countries with a special focus on child and adolescent mental health. *European Child & Adolescent Psychiatry, 27*(4), 389-399.	2018	Review and commentary	Adults and children European focus Includes political issues
(Nakeyar et al., 2018)	Nakeyar, C., Esses, V. & Reid, G. J. (2018). The psychosocial needs of refugee children and youth and best practices for filling these needs: A systematic review. *Clinical Child Psychology & Psychiatry, 23*(2), 186-208.	2018	Systematic review	Psychosocial needs Refugee children Practice implications

Citation	Reference	Year	Nature of paper	Comments
(Kien et al., 2018)	Kien, C., Sommer, I., Faustmann, A., Gibson, L., Schneider, M., Krczal, E. ... & Gartlehner, G. (2018). Prevalence of mental disorders in young refugees and asylum seekers in European Countries: A systematic review. *European Child & Adolescent Psychiatry, 27*, 27.	2018	Systematic	Children and adolescents European focus
(Hodes & Vostanis, 2018)	Hodes, M. & Vostanis, P. (2018). Practitioner review: Mental health problems of refugee children and adolescents and their management. *Journal of Child Psychology and Psychiatry, 60*(7), pp 716–731.	2018	Practitioner review	Children and adolescent
(Vossoughi et al., 2018)	Vossoughi, N., Jackson, Y., Gusler, S. & Stone, K. (2018). Mental health outcomes for youth living in refugee camps: A review. *Trauma, Violence, and Abuse, 19*(5), 528-542. doi:10.1177/1524838016673602	2018	Systematic review	Youth Camps not detention
(El Baba & Colucci, 2018)	El Baba, R. & Colucci, E. (2018). Post-traumatic stress disorders, depression, and anxiety in unaccompanied refugee minors exposed to war-related trauma: A systematic review. *International Journal of Culture and Mental Health, 11*(2), 194-207.	2018	Systematic review- post settlement stressors but not specifically detention	UAM not detention Useful overview of

Citation	Reference	Year	Nature of paper	Comments
(Guruge & Butt, 2015)	Guruge, S. & Butt, H. (2015). A scoping review of mental health issues and concerns among immigrant and refugee youth in Canada: Looking back, moving forward. *Canadian Journal of Public Health, 106*(2), e72-78. doi:10.17269/cjph.106.4588	2015	Scoping review Not detention	Pre- and post-migration issues Canadian focus
(Fazel et al., 2012)	Fazel, M., Reed, R. V., Panter-Brick, C. & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *Lancet, 379*(9812), 266-282.	2012	Systematic review	Post-settlement stressors, high-income countries Not specifically detention but mentions it
(Reed et al., 2012)	Reed, R. V., Fazel, M., Jones, L., Panter-Brick, C. & Stein, A. (2012). Mental health of displaced and refugee children resettled in low-income and middle-income countries: Risk and protective factors. *The Lancet, 379*(9812), 250-265.	2012	Systematic review	Children and adolescent Low- and middle-income countries Post-settlement stressors Not specifically detention but mentions it
(Bronstein & Montgomery, 2011)	Bronstein, I. & Montgomery, P. (2011). Psychological distress in refugee children: a systematic review. *Clinical Child & Family Psychology Review, 14*(1), 44-56.	2011	Systematic review	Not detention

Citation	Reference	Year	Nature of paper	Comments
(Lustig et al., 2004)	Lustig, S. L., Kia-Keating, M., Knight, W. G., Geltman, P., Ellis, H., Kinzie, D. J. ... & Saxe, G. N. (2004). Review of child and adolescent refugee mental health. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(1), 24-36.	2004	Systematic review	Refugees Children with families and UAMs Not detention
(Fazel & Stein, 2002)	Fazel, M. & Stein, A. (2002). The mental health of refugee children. *Archives of Disease in Childhood, 87*(5), 366-370.	2002	Review	Refugee children and adolescents Stages of journey and risk. Practice implications
(Rousseau, 1995)	Rousseau, C. (1995). The mental health of refugee children. *Transcultural Psychiatric Research Review, 32*(3), 299-331	1995	Review	Refugee children and adolescents Not detention Good overview of family and cultural factors

Table D.3: Review and commentary papers about immigration detention of children

Citation	Reference	Year	Nature of paper	Comments
(Fazel et al., 2005)	Fazel, M., Wheeler, J. & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet, 365*(9467), 1309-1314.	2005	Systematic review	Adults Mention of children
(Silove et al., 2007)	Silove, D. M., Austin, P. & Steel, Z. (2007). No refuge from terror: The impact of detention on the mental health of trauma-affected refugees seeking asylum in Australia. *Transcultural Psychiatry, 44*(3), 359-393.	2007	Review	Mainly adults Includes human rights inquiry data Mention of children
(Newman & Steel, 2008)	Newman, L. K. & Steel, Z. (2008). The child asylum seeker: Psychological and developmental impact of immigration detention. *Child and Adolescent Psychiatric Clinics of North America, 17*(3), 665-683.	2008	Review	International review Australian focus Includes HREOC data
(Robjant et al., 2009)	Robjant, K., Hassan, R. & Katona, C. (2009). Mental health implications of detaining asylum seekers: Systematic review. *The British Journal of Psychiatry, 194*(4), 306-312.	2009	Systematic review	Predominantly about adults but includes a section on children, adolescents and their families
(Hodes, 2010)	Hodes, M. (2010). The mental health of detained asylum-seeking children. *European Child & Adolescent Psychiatry, 19*(7), 621-623. doi:10.1007/s00787-010-0093-9.	2010	Review	Detained children

Citation	Reference	Year	Nature of paper	Comments
(Kronick et al., 2011)	Kronick, R., Rousseau, C. & Cleveland, J. (2011). Mandatory detention of refugee children: A public health issue? *Paediatrics & Child Health, 16*(8), e65-e67.	2011	Comment with vignette	Includes human rights inquiries
(Jureidini & Burnside, 2011)	Jureidini, J. & Burnside, J. (2011). Children in immigration detention: A case of reckless mistreatment. *Australian and New Zealand Journal of Public Health, 35*(4), 304-306.		Commentary	Australia as a focus Ethical issues
(Dudley et al., 2012)	Dudley, M., Steel, Z., Mares, S. & Newman, L. (2012). Children and young people in immigration detention. *Current Opinion in Psychiatry, 25*(4), 285-292.		Review and commentary	Mental health and human rights
(Farmer, 2013)	Farmer, A. (2013). The impact of immigration detention on children. *Forced Migration Review* (44), 14.		Commentary	Human rights focus
(Fazel et al., 2014)	Fazel, M., Karunakara, U. & Newnham, E. A. (2014). Detention, denial, and death: Migration hazards for refugee children. *The Lancet Global Health, 2*(6), e313– e314. http://dx.doi.org/10.1016/S2214-109X(14)70225-6	2014	Commentary	Children

Citation	Reference	Year	Nature of paper	Comments
(Mares, 2016a)	Mares, S. (2016). Fifteen years of detaining children who seek asylum in Australia – evidence and consequences. *Australas Psychiatry, 24*(1), 11-14.	2016	Review and commentary	Includes data from human rights inquiries Australia as a focus
(Isaacs & Triggs, 2018)	Isaacs, D. & Triggs, G. (2018). Australia's immigration policy violates United Nations Convention on the Rights of the Child. *Journal of Paediatrics and Child Health, 54*(8), 825-827.	2018	Commentary	Human rights and health Australia
(von Werthern et al., 2018)	von Werthern, M., Robjant, K., Chui, Z., Schon, R., Ottisova, L., Mason, C. & Katona, C. (2018). The impact of immigration detention on mental health: A systematic review. *BMC Psychiatry, 18*(1), 382.	2018	Systematic review	Predominantly about adults but includes a section on children, adolescents and their families
(Triggs, 2018)	Triggs, G. (2018). The impact of detention on the health, wellbeing and development of children: Findings from the second National Inquiry into Children in Immigration Detention. In M. C. a. L. B. Benson (Ed.) *Protecting Migrant Children: In Search of Best Practice*. Cheltenham: Edward Elgar Publishing.	2018	Review chapter	Focus on Australian human rights inquiries on detention of children

Citation	Reference	Year	Nature of paper	Comments
(Wood, 2018)	Wood, L. C. (2018). Impact of punitive immigration policies, parent-child separation and child detention on the mental health and development of children. *BMJ Paediatrics Open, 2*(1)	2018	Review and Commentary Family separation and child detention	US-Mexico border International context
(Foong et al., 2019)	Foong, A., Arthur, D., West, S., Kornhaber, R., McLean, L. & Cleary, M. (2019). The mental health plight of unaccompanied asylum-seeking children in detention. *Journal of Advanced Nursing (John Wiley & Sons, Inc.), 75*(2), 255-257	2019	Review and commentary	Australian focus
(Sriraman, 2019)	Sriraman, N. K. (2019). Detention of immigrant children – a growing crisis; What is the pediatrician's role? *Current Problems in Pediatric and Adolescent Health Care, 49*(2), 50-53.	2019	Commentary	US focus Written for paediatricians

Table D.4: Post-migration stressors and adjustment, not detention

Citation	Reference
(Muller et al., 2019)	Muller, L. R. F., Buter, K. P., Rosner, R. & Unterhitzenberger, J. (2019). Mental health and associated stress factors in accompanied and unaccompanied refugee minors resettled in Germany: A cross-sectional study. *Child & Adolescent Psychiatry & Mental Health [Electronic Resource], 13*, 8.
(Mitra & Hodes, 2019)	Mitra, R. & Hodes, M. (2019). Prevention of psychological distress and promotion of resilience amongst unaccompanied refugee minors in resettlement countries. *Child: Care, Health and Development, 45*(2), 198-215.
(Walker & Zuberi, 2019)	Walker, J. & Zuberi, D. (2019). School-aged Syrian refugees resettling in Canada: Mitigating the effect of pre-migration trauma and post-migration discrimination on academic achievement and psychological well-being. *Journal of International Migration and Integration*. doi:10.1007/s12134-019-00665-0
(Sleijpen et al., 2019)	Sleijpen, M., van der Aa, N., Mooren, T., Laban, C. J. & Kleber, R. J. (2019). The moderating role of individual resilience in refugee and Dutch adolescents after trauma. *Psychological Trauma: Theory, Research, Practice and Policy, 16*, 16.
(Khan et al., 2019)	Khan, N. Z., Shilpi, A. B., Sultana, R., Sarker, S., Razia, S., Roy, B. ... & McConachie, H. (2019). Displaced Rohingya children at high risk for mental health problems: Findings from refugee camps within Bangladesh. *Child: Care, Health and Development, 45*(1), 28-35.
(Horgan & Ní Raghallaigh, 2019)	Horgan, D. & Ní Raghallaigh, M. (2019). The social care needs of unaccompanied minors: The Irish experience. *European Journal of Social Work, 22*(1), 95-106.
(d'Abreu, Castro-Olivo & Ura, 2019)	d'Abreu, A., Castro-Olivo, S. & Ura, S. K. (2019). Understanding the role of acculturative stress on refugee youth mental health: A systematic review and ecological approach to assessment and intervention. *School Psychology International, 40*(2), 107-127.
(Javanbakht et al., 2018)	Javanbakht, A., Rosenberg, D., Haddad, L. & Arfken, C. L. (2018). Mental health in Syrian refugee children resettling in the United States: War trauma, migration, and the role of parental stress. *Journal of the American Academy of Child & Adolescent Psychiatry, 57*(3), 209-21.

Citation	Reference
(Beni Yonis et al., 2019)	Beni Yonis, O., Khader, Y., Jarboua, A., Al-Bsoul, M. M., Al-Akour, N., Alfaqih, M. A. ... & Amarneh, B. (2019). Post-traumatic stress disorder among Syrian adolescent refugees in Jordan. *Journal of Public Health, 30*, 30.
(Lau et al., 2018)	Lau, W., Silove, D., Edwards, B., Forbes, D., Bryant, R., McFarlane, A. ... & O'Donnell, M. (2018). Adjustment of refugee children and adolescents in Australia: Outcomes from wave three of the Building a New Life in Australia study. *BMC Med, 16*(1), 157.
(Fazel, 2018)	Fazel, M. (2018). Refugees and the post-migration environment. *BMC Med, 16*(1), 164.
(Bryant et al., 2018)	Bryant, R. A., Edwards, B., Creamer, M., O'Donnell, M., Forbes, D., Felmingham, K. L. ... & McFarlane, A. C. (2018). The effect of post-traumatic stress disorder on refugees' parenting and their children's mental health: A cohort study. *The Lancet Public Health, 3*(5), e249-e258.
(Norredam, Nellums, Nielsen, Byberg & Petersen, 2018)	Norredam, M., Nellums, L., Nielsen, R. S., Byberg, S. & Petersen, J. H. (2018). Incidence of psychiatric disorders among accompanied and unaccompanied asylum-seeking children in Denmark: A nation-wide register-based cohort study. *European Child and Adolescent Psychiatry, 27*(4), 439-446. doi:10.1007/s00787-018-1122-3.
(Teicher, 2018)	Teicher, M. H. (2018). Childhood trauma and the enduring consequences of forcibly separating children from parents at the United States border. *BMC Medicine, 16*(1).
(Triantafyllou et al., 2018; Van der Kolk, 2005)	Triantafyllou, K., Othiti, I., Xylouris, G., Moulla, V., Ntre, V., Kovani, P. ... & Anagnostopoulos, D. (2018). Mental health and psychosocial factors in young refugees, immigrants and Greeks: A retrospective study. *Psychiatriki, 29*(3), 231-239.
(Zucker & Greene, 2018)	Zucker, H. A. & Greene, D. (2018). Potential child health consequences of the federal policy separating immigrant children from their parents. *JAMA – Journal of the American Medical Association, 320*(6), 541-542.
(Miller, Hess, Bybee & Goodkind, 2018)	Miller, A., Hess, J. M., Bybee, D. & Goodkind, J. R. (2018). Understanding the mental health consequences of family separation for refugees: Implications for policy and practice. *American Journal of Orthopsychiatry, 88*(1), 26.

Citation	Reference
(Sim, Fazel et al., 2018)	Sim, A., Fazel, M., Bowes, L. & Gardner, F. (2018). Pathways linking war and displacement to parenting and child adjustment: A qualitative study with Syrian refugees in Lebanon. *Social Science & Medicine, 200*, 19-26.
(Zwi et al., 2018)	Zwi, K., Woodland, L., Williams, K., Palasanthiran, P., Rungan, S., Jaffe, A. & Woolfenden, S. (2018). Protective factors for social-emotional well-being of refugee children in the first three years of settlement in Australia. *Archives of Disease in Childhood, 103*(3), 261-268.
(El-Khani, Ulph, Peters & Calam, 2017)	El-Khani, A., Ulph, F., Peters, S. & Calam, R. (2017). Syria: Coping mechanisms utilised by displaced refugee parents caring for their children in pre-resettlement contexts. *Intervention: Journal of Mental Health and Psychosocial Support in Conflict Affected Areas, 15*(1), 34-50.
(Dennis, Merry & Gagnon, 2017)	Dennis, C. L., Merry, L. & Gagnon, A. J. (2017). Postpartum depression risk factors among recent refugee, asylum-seeking, non-refugee immigrant, and Canadian-born women: Results from a prospective cohort study. *Social Psychiatry & Psychiatric Epidemiology, 52*(4), 411-422.
(DeJong et al., 2017)	DeJong, J., Sbeity, F., Schlecht, J., Harfouche, M., Yamout, R., Fouad, F.M. ... & Robinson, C. (2017). Young lives disrupted: Gender and well-being among adolescent Syrian refugees in Lebanon. *Conflict & Health*
(Jakobsen et al., 2017)	Jakobsen, M., Meyer DeMott, M. A., Wentzel-Larsen, T. & Heir, T. (2017). The impact of the asylum process on mental health: A longitudinal study of unaccompanied refugee minors in Norway. *BMJ Open, 7*(6), e015157.
(LeBrun et al., 2015)	LeBrun, A., Hassan, G., Boivin, M., Fraser, S.-L., Dufour, S. & Lavergne, C. (2015). Review of child maltreatment in immigrant and refugee families. *Canadian Journal of Public Health, 106*(7), eS45-eS56.
(Zwi & Mares, 2014)	Zwi, K. & Mares, S. (2014). Commentary: Reducing further harm to asylum-seeking children: The global human rights context. *International journal of epidemiology, 43*(1), 104-106.
(Goosen et al., 2014)	Goosen, S., Stronks, K. & Kunst, A. E. (2014). Frequent relocations between asylum-seeker centres are associated with mental distress in asylum-seeking children: A longitudinal medical record study. *International Journal of Epidemiology, 43*(1), 94-104.

Citation	Reference
(Vervliet et al., 2014)	Vervliet, M., Lammertyn, J., Broekaert, E. & Derluyn, I. (2014). Longitudinal follow-up of the mental health of unaccompanied refugee minors. *European Child & Adolescent Psychiatry, 23*(5), 337-346.
(Alink et al., 2013)	Alink, L. R., Euser, S., van IJzendoorn, M. H. & Bakermans-Kranenburg, M. J. (2013). Is elevated risk of child maltreatment in immigrant families associated with socioeconomic status? Evidence from three sources. *International Journal of Psychology, 48*(2), 117-127.
(Lauritzen & Sivertsen, 2012)	Lauritzen, C. & Sivertsen, H. (2012). Children and families seeking asylum in northern Norway: Living conditions and mental health. *International Migration, 50*(6), 195-210.
(Montgomery, 2010)	Montgomery, E. (2010). Trauma and resilience in young refugees: A 9-year follow-up study. *Development & Psychopathology, 22*(2), 477-489.
(Hodes et al., 2008)	Hodes, M., Jagdev, D., Chandra, N. & Cunniff, A. (2008). Risk and resilience for psychological distress amongst unaccompanied asylum seeking adolescents. *Journal of Child Psychology & Psychiatry & Allied Disciplines, 49*(7), 723-732.
(Bean et al., 2007a)	Bean, T., Derluyn, I., Eurelings-Bontekoe, E., Broekaert, E. & Spinhoven, P. (2007). Comparing psychological distress, traumatic stress reactions, and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents. *Journal of Nervous & Mental Disease, 195*(4), 288-297.
(Heptinstall et al., 2004)	Heptinstall, E., Sethna, V. & Taylor, E. (2004). PTSD and depression in refugee children. *European Child & Adolescent Psychiatry, 13*(6), 373-380. doi:http://dx.doi.org/10.1007/s00787-004-0422-y.
(Sourander 1998)	Sourander, A. (1998). Behavior problems and traumatic events of unaccompanied refugee minors. *Child Abuse & Neglect, 22*(7), 719-727.

Appendix E: Additional information about methodological approaches to data collection and reporting

Qualitative, quantitative and mixed methods approach

Studies that describe 'how many' or 'how much' and report outcomes and their numerical significance are described as quantitative (Wadsworth, 2011). There are arguments, underpinned by a positivist epistemology, that quantitative data is more objective or replicable than qualitative data.

In contrast, qualitative research is considered more open ended and exploratory. Many qualitative studies involve engagement "with other people's language, the stories they tell and/or the experiences they have" (Shaw, 2010). Shaw acknowledges the responsibilities that go with this and the requirement for reflexivity given that the job of researchers, in her view, is "to make sense of these stories and experiences in a meaningful way with a view to learning more about humankind and, often, to effect change, whether that be in terms of influencing policy and practice or enhancing understanding at an individual or institutional level" (Shaw, 2010, p.234).

An increasing number of studies use a mixed methods approach, combining and/or comparing data collected using both qualitative and quantitative methods (Bryman, 2016). This has a number of potential outcomes, including enabling mutual corroboration or comparison, known as 'triangulation', of data and allowing the weaknesses of individual approaches to be "offset" (Bryman, 2016, pp. 105-106). There are, however, risks of data redundancy, wasted time for participants and researchers and unexpected and contradictory findings. Bryman argues that the rationale for using a mixed methods approach needs to be articulated for any particular study (Bryman, 2016, p. 110).

Quantitative methods

Case study and case series

The case study and the case series, where a number of related cases are considered together, have a long history in medicine and other clinical sciences. These approaches typically use a range of sources and kinds of information to investigate and report on a

particular circumstance or context in some depth, such as a particular clinical presentation, institution or environment. The method is useful for in-depth description of living or institutional systems (Wadsworth, 2011, p. 176), for detecting novel information, or for describing a rare event, and in this way is said to contribute to the development of new knowledge and of hypotheses (Vandenbroucke, 2001).

The quality of the data generated depends on the methods used. When comprehensive clinical assessment is undertaken over time, by an expert with access to all information, such as outlined in the LEAD approach (the acronym standing for 'longitudinal, expert, all data') (Spitzer, 1983, p. 409), this strengthens the validity of the data collected. A case series potentially has more power than an individual study, because it allows data to be collated and analysed rather than simply examined and reported. The weakness of these approaches is in the small number of subjects and the extent to which the findings can be generalised or considered representative.

Self-report questionnaires

Self-report measures are usually brief questionnaires, providing the respondent with a limited number of response options. In medicine they are used as screening tools and seen as an efficient method for identifying people at risk of or likely to have a significant medical or psychiatric disorder and who require more comprehensive assessment. The measures used in the body of work I am describing here are the Kessler 10 (K10) and the Strengths and Difficulties Questionnaire (SDQ).

The K10 is a self-report scale that screens for psychological distress (Brooks, Beard & Steel, 2006). High distress scores indicate the likelihood that the person has a psychiatric disorder. The scale has been widely validated, including with refugee populations (Sulaiman-Hill & Thompson, 2010).

The SDQ is a brief 20-item screening questionnaire completed by the parent or carer for children aged 3–17; it can be self-reported for children aged 12–17 years. There are also teacher-report versions. It is used in population and clinical studies to identify those at risk of mental illness and is scored to provide a 'total difficulty' score ranging from 0 to 40, plus 5-factor subscales (hyperactivity-inattention, emotional symptoms, peer problems, conduct

problems, and prosocial behaviour) (Goodman, 2001; Vostanis, 2006). It has been widely used, including with migrant and refugee children (Achenbach, Becker, Döpfner, Heiervang, Roessner, Steinhausen & Rothenberger, 2008).

Secondary data analysis

Secondary analysis involves the reconsideration of a pre-existing data set derived from another study or source. It can be used to reconsider the original research question by using a different technique, or to present differing or additional interpretations of the original data to ask new research questions or to verify the findings of previous research (Heaton, 2008). This approach raises ethical questions about consent and protection of original participants (Grinyer, 2009).

Cohort comparison or case controlled study

Cohort studies are described as the best method for determining the incidence and natural history of a condition, and they may be prospective or retrospective and enable comparison of separate cohorts (Mann, 2003). They are useful when a randomised controlled trial is unethical or impossible. A cohort study can also assess more than one outcome variable. The major disadvantage of cohort comparison studies is the difficulty of controlling for all other factors that potentially differ between the two groups and that might affect outcomes., known as confounding variables. In addition, there is the risk of bias if samples selected and compared are not representative of the larger population being studied.

Qualitative methods

Participant observation and ethnographic approaches

Narrative methods and participant observer accounts enable the inclusion of subjective/lived experience and privilege the subjectivity and agency of participants in ways that many other methodologies do not.

Jorgensen (2015) describes participant observation as “a unique method for investigating human existence whereby the researcher more or less actively participates with people in commonplace situations and everyday life settings while observing and otherwise collecting

information" (Jorgensen, 2015, p.1). The paper argues that through participation it is possible to observe and gather many forms of data that are not accessible to an external observer. This is a particularly appropriate and useful method in circumstances where there are important differences in the views of insiders (those who are part of the setting or group), as opposed to outsiders, and the phenomenon is somehow obscured or hidden from public view. In my experience, immigration detention centres are such a circumstance.

Structured and semi-structured interviews

In a structured interview "the interviewer must faithfully ask in a pre-determined sequence, a series of closed pre- defined questions" (Nordgaard, Sass & Parnas, 2013, p.360). The aim is to obtain data from different subjects/people that can be compared or collated, generating objective, quantitative data, or, as Nordgaard and colleagues write, enabling experiences lived in the first person "to provide objective data that can be shared for diagnosis, treatment and research" (Nordgaard et al., 2013, p. 354). It has been argued that the "fully structured interview is neither theoretically adequate nor practically valid in obtaining psycho-diagnostic information" (Nordgaard et.al., 2013, p. 353), because it does not adequately explore "experience and subjectivity". These authors note that "She [the psychiatrist] confronts not a thing or body part but a person [their emphasis], another embodied consciousness and its realm of meaning … What the patient manifests is not an isolated series of independent referring symptoms/signs but rather certain wholes of interpenetrating experiences, feelings, expressions, beliefs, and actions, all permeated by biographical detail" (Nordgaard, et.al., 2013, p.359).

Less structured and more conversational or phenomenological interviews rely on the rapport established between participants. They provide opportunities for people to tell their story in their own way, with the emphasis more on subjective experience and qualitative data generation.

Children's narratives and drawings

See Appendix F.

Invited editorials, opinion pieces and book chapters

An editorial can be described as writing that provides and synthesises background information and evidence and then provides an opinion and the justification or explanation for this opinion, based on the evidence (Lowell, 2008). This opinion can provide a perspective or overview and/or include a persuasive element (Day & Gastel, 1989). Book chapters also provide background context and evidence rather than new data and, depending on the editorial instructions, focus on particular aspects or applications of the evidence, such as clinical applications or ethical aspects of the subject (Day & Gastel, 1989).

Data integration and synthesis

There are different approaches to integrating and interpreting data of diverse kinds into a coherent set of results and conclusions.

Integrative syntheses involve "assembling and pooling data and require a basic comparability between phenomena studied so that the data can be aggregated for analysis" (Dixon-Woods et al., 2005, p. 46). Dixon-Woods and colleagues go on to suggest that "integrative syntheses are those where the focus is on summarising data, and where the concepts (or variables) under which data are to be summarised are assumed to be largely secure and well specified". In contrast, these authors define an interpretive synthesis as having a "concern with the development of concepts, and with the development and specification of theories that integrate those concepts" (Dixon-Woods et al., 2005, p. 46). The main outcomes can then be summarised as either data from an integrative synthesis or theory from an interpretive synthesis. Importantly, these processes are interrelated, rather than entirely separate or distinct, with the above authors concluding that, "In practice, many approaches involve elements both of interpretation and integration" (Dixon-Woods et al., 2005, p. 47). This thesis includes both integrative and interpretive syntheses.

Mays and colleagues (2005) condense the range of approaches to data synthesis and integration into four categories: (1) narrative, which includes traditional literature reviews, thematic analysis, and various forms of narrative and realist synthesis and mapping; (2) qualitative approaches, which convert all available evidence into qualitative form, including for example meta-ethnography and qualitative cross-case analysis; (3) quantitative

approaches, converting all evidence into quantitative with techniques such as ‘quantitative case survey’ or ‘content analysis’; and (4) Bayesian meta-analysis and decision analysis, which can be used to convert qualitative evidence into quantitative form. The choice of approach is contingent on the aim of the review and nature of the available evidence, and often more than one approach will be required (Mays, Pope & Popay, 2005).

Appendix F: Children's narratives and drawings – interpretation, access and consent

It is accepted that children use drawings and play as ways to communicate and process their experiences (Einarsdottir, Dockett & Perry, 2009). The content of drawings and how they are made is influenced by external factors such as the family context and those intrinsic to the child, such as developmental level (Oğuz, 2010). The nature and content of children's drawings is also influenced by the setting in which the drawings are made and who the child is with.

There is experimental evidence that drawing can increase the amount of information that young children provide about their experiences (Gross & Hayne, 1998). Discussion with children about their drawings and attention to the narratives they tell can provide a particularly rich understanding of the child's intentions and contribute to meaning-making (Cox, 2005). Research or the ascription of meaning to drawings in the absence of discussion and narration with the child provides a more limited interpretation and risks fixing or ascribing meanings other than those intended by the child (Cox, 2005). There is an additional literature on the therapeutic use of drawing and art therapy with traumatised children (Looman, 2006; Malchiodi, 2001; Winnicott, 1971). A recent Australian book on drawings by displaced Syrian children living in temporary camps in Lebanon is a testimony to the desire of children to communicate their experience through drawings, and to the communicative power of those drawings (Quilty, 2018).

Interpretation of children's drawings

There is no validated system for the assessment of the content of children's drawings, and historically the focus of this has changed from analysis of developmental to emotional and process factors (Malchiodi, 1998; Thomas & Silk, 1990). Several different approaches, such as Draw a Person, House Tree Person and Kinetic Family Drawings (described in Matto, 2007) have been proposed to use as tools in assessment of emotional disturbance and as developmental difficulties, and attempts have been made at standardising their scoring. Many factors influence the information presented in a drawing "children's knowledge of the drawing topic itself, their interpretation of what aspects of that information are important

to present, and their capacity to produce a drawing showing that information" (Thomas & Silk, 1990, p. 106).

My training in child psychiatry included information about the many different ways that drawings have been understood (Malchiodi, 1998), as well as the potential therapeutic uses of drawing in clinical work with children (Winnicott, 1971; Malchiodi, 2001). This informs my approach to the drawings by detained children that are included in the thesis. Children's drawings can convey a situation, including a "traumatic situation as it happened", but also aspects of the emotional conflicts they were experiencing related to the trauma (Brafman, 2012, pp. 10-11). It is not surprising that, given the opportunity, many detained children used drawing to communicate and record something about their experiences (AHRC, 2014).

Publication of drawings by detained children

Images are powerful. The plight of six-year-old child SB, who required repeated hospitalisations for rehydration and refeeding after he lapsed into a withdrawn state (these days known as 'resignation syndrome' or 'pervasive refusal syndrome') (Newman, 2019), captured public attention in 2002 after video footage of him, listless and mute, was smuggled out of detention by a journalist using a camera reportedly hidden inside a cooked chicken. Creative responses to the obstacles associated with reporting on the situation of detained asylum seekers abound, and they imply recognition of the power of images in addition to words. A few photographs that I took during visits to detention centres have been included in Chapter 6.

Two drawings by SB, representing his imprisonment and witnessing of a person bleeding after cutting their wrists, were discussed in Chapter 6 (Zwi et.al., 2003).

The academic and grey literature includes a small number of studies using various approaches to the inclusion and analysis of detained children's drawings and/or images of their 'creations'. The HREOC report in 2004 (HREOC, 2004) included photographs and drawings or direct quotation of children's words. In 2014 the AHRC inquiry (AHRC, 2014) collected around 300 pictures drawn by adults and children and incorporated 13 drawings by detained children into its report. As RANZCP consultants to that AHRC inquiry, my paediatric colleague Karen Zwi and I were involved in the development of the inquiry

methodology and were present when children detained on Christmas Island and in Darwin detention facilities were given drawing materials and invited to draw pictures to tell us about their lives.

Children's drawings from detention are particularly powerful because they remind us of the apparent innocence of childhood in contrast to the content of the experiences portrayed. Mayhew writes: "The value of drawings is less as visual evidence of the conditions of child detention, and more as testimony of the emotional response to detention" (Mayhew, 2015, p.3). I disagree with this. The children's drawings from detention can be understood as both direct witness accounts of what happened, who was there, who did what. There is no doubt that "they offer emotive testimony and insist that viewers bear witness to the trauma and tragedy of the mandatory detention of all asylum seekers" (Mayhew, 2015, p.4). They also demonstrate the agency and personhood, the subjectivity and experience of individual children.

A single Australian paper identified in the scoping review includes secondary analysis of two drawings by detained children, one sourced from the 2014 AHRC inquiry, and one that was reproduced in a national newspaper. The authors of the paper use the drawings as a way to understand the children's experience of detention but identify the limitations of this 'second hand' approach and caution against generalising from two images to the experiences of all detained children (Lenette, et.al., 2017). A single Canadian paper (Kronick et al., 2018) includes photographs of 'worlds' created by detained children and which the children then described and told stories about.

Permissions and ownership of detained children's drawings

Four of the papers in the thesis (Mares, et.al., 2002; Mares & Zwi, 2015; Steel, Mares, Newman, Blick & Dudley, 2004; Zwi & Mares, 2015) include children's drawings or statements and direct quotations of the children's words; these were discussed in Chapter 6.

Since publication of the AHRC inquiry report (AHRC, 2014), the permission given to me and other third parties by the AHRC has varied in relation to further use, reproduction or analysis of the drawings collected during the inquiry. In 2014, in response to a question

about using the drawings in media interviews and in papers published about the inquiry (Mares & Zwi, 2015; Zwi & Mares, 2015), I received a response by email dated 21 March 2014[15] which included the following:

Question: Are they [Mares and Zwi] allowed to use the drawings (provided they remove any numbering)?

Response: Yes – but not all identifiers regarding the numbers need to be removed because this is powerful – the term 'boat ID' can remain but the number should be removed to protect privacy.

In addition, a copy of legal opinion provided to AHRC staff members of the inquiry team, dated 2 December 2014 and entitled *Use of drawings by children in detentio*n, was provided, and this was emailed to me in February 2018. It states in part (pp. 3-4):

Subsection 11(1)(g) provides that it is a function of the Commission to promote an understanding and acceptance, and the public discussion, of human rights in Australia, in the context of the inquiry, one way in which this would reasonably be done would be through promotion of the report of the inquiry and its findings. As[162] the drawings are an integral part of the report and a mechanism by which attention can be drawn to it and the findings, it is arguable that the implied licence does include a sublicense to use the drawings for the purpose of promotion of the report and the findings and work of the inquiry. It would not extend to any use beyond this and if such a request is made it should be refused.

Correspondence by email in 2015 to another party requesting to use the drawings in an exhibition included the following reply:[17]

Unfortunately because of the manner in which they were obtained, the Commission does not own the copyright to those pictures and so we are not freely available to provide them to you. The legal advice we have been given is that they cannot be provided for use for such a

[15] Personal communication SB to SM 21 March 2014, 11.02 am.

[16] Email dated 6th November 2015, AA to KZ

public exhibition or a published analysis as you've set out below. I share your frustration around this, considering how they were handed to us.
Though we can't give permissions for you to use them for the above purpose, they are available for viewing on the Commission's flickr page here https://www.flickr.com/photos/23930202@N06/albums/72157645938124048 which has over 300 of those pictures with identifiers redacted. You are free to view and share the link to that page with health professionals and the general public, which can definitely help get the message out.

In September 2017 and again on 25 February 2018 I wrote to the AHRC, in part to indicate that in the PhD I would:

write about the obstacles to research in conventional ways to explain the limitations of the data but also the various sources of evidence available, which definitely includes the drawings – they are direct evidence of the children's experience. They are also a way of giving voice to the children and illustrating what daily life was like, for example, and their awareness of the injustice. I would argue that they are a way of honouring the children, rather than just talking about them we include their communications-as the AHRC did selectively in the Inquiry report.

Specifically, my request is advice about;

1/ whether I can use some of the drawings as images in the PhD to illustrate elements of life in detention – as Karen Zwi and I did in our 2015 papers.

2/ As there is definitely enough material for a separate thematic analysis of the drawings held by the Commission, or just the copies I have, this would be a separate study potentially requiring consideration for ethics approval. What would be the Commission's current attitude be to this?

The reply, dated 27 Feb 2018, included another copy of the legal advice dated 2 December 2014, and stated:[3]

[3] SB to SM personal communication

Hi Sarah,

I have followed up with the Commission's legal department. Unfortunately the advice remains the same as we provided to you in 2015 (see attached a document from legal in more detail).

In brief, due to the circumstances in which the drawings were obtained, the Commission does not own copyright and does not have an express licence to use them. It does have an implied licence to use them for the purposes of the inquiry and to sublicense other uses which are sufficiently connected to the inquiry - such as media reporting on the inquiry.

It does not appear that the licence would extend to the work you have proposed.

Apologies that we cannot assist you more.

Given the various interpretations of this advice and the fact that the images are already included in published papers that report data collected during the inquiry, I have only included copies and discussion of images created by children as part of the AHRC 2014 inquiry that were previously published with permission in the selected papers that underpin the thesis.

The drawings under discussion in the above correspondence, and many more that were provided by detained adults and children during the 2014 AHRC inquiry, remain available online, including on the AHRC website. Permission was obtained from the AHRC to include the drawings in the papers published after my visits with the inquiry to detained children (Mares & Zwi, 2015; Zwi & Mares, 2015). In Chapter 6 I have only reproduced and discussed drawings that had already been included in the published papers that make up the thesis. This includes drawings obtained during visits to families in Woomera IDC in 2002, where permission was obtained at the time from the children and families (Mares et al., 2002), and from children families held on Christmas Island and Darwin detention facilities in 2014, where permission was obtained from the AHRC. There is also discussion of two drawings by SB that were included in a paper published in 2004, where consent to include them in the publication was obtained by the primary author (Steel, Mares, Newman et.al., 2004).

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