

**Submission to the Joint Select Committee on Australia's Immigration Detention Network
September 2011**

OVERVIEW

Many of the anecdotes and observations referred to in this submission were made whilst I was employed by the Health Service Provider as a psychologist, on Christmas Island during early 2010. I am at risk of litigation if I speak out publicly about my role, my work and what I observed during my time on Christmas Island but I feel this new inquiry may be the best time to speak out about my experiences if they are going to be of any use to those who still find themselves a part of Australia's immigration detention network. I was informed by the Committee secretary that I would be afforded a parliamentary privilege for any part of my submission that may break the terms and conditions of the contract that I signed with my past employer; however, I'm still fearful about speaking out. Therefore, I would like to have my name withheld and remain anonymous. I will also not refer to the health service provider that employed me by its company name, in case it leads to further litigation. I trust you know the organisation that I am referring to. I think people need to start using their name more often, like the way people refer to Serco and DIAC. For the health service provider so far has managed to escape the bulk of public scrutiny and criticism, even though it is meant to be providing one of the most vital services inside Australia's immigration detention network.

I was originally employed to work as a psychologist for the company for a three month contract in 2010 (My contract was terminated prematurely as I was fired from the position, I believe, for fulfilling my ethical responsibility as a psychologist, which puts the well-being of the client before company rules and regulations). At that time I was the only psychologist employed as part of the company's "multidisciplinary" mental health team which attended to the mental health needs of over 1800 detainees (men, women, unaccompanied children and families) across three different sites. The other disciplines that made up the multidisciplinary mental health team were mental health nurses. Obviously, I would never speak about matters that would breach the confidentiality of any of the detainees I worked with; however there were many systemic and operational issues that seemed to prevent me from being able to do my job according to best practice. I will endeavour to outline each of these below. However, I think Australian Psychologist, Lyn Bender, who had been in a similar position at Woomera in 2002 put it very well when she wrote:

"I realised I had a profound ethical dilemma. There was a deep conflict of interest. In being compliant to the administration and its political allegiances, I was unable to ensure the protection and my duty of care towards these vulnerable people." <http://www.eurekastreet.com.au/article.aspx?aeid=28323>

While in this submission I draw upon my own personal experiences and anecdotes, I am of the strong belief that my experiences capture broader, systemic problems within Australia's Immigration Detention Network. I trust that this submission is read in such a light.

My submission is relevant to the following Terms of Reference as set out by the Committee:

- (a) Any reforms needed to the current Immigration Detention Network in Australia;
- (b) The impact of length of detention and the appropriateness of facilities and services for asylum seekers;
- (c) The resources, support and training for employees of Commonwealth agencies and/or their agents or contractors in performing their duties;
- (d) The health, safety and wellbeing of asylum seekers, including specifically children, detained within the detention network;

- (f) The effectiveness and long-term viability of outsourcing immigration detention centre contracts to private providers;
- (g) The impact, effectiveness and cost of mandatory detention and any alternatives, including community release; and
- (h) The reasons for and nature of riots and disturbances in detention facilities;
- (i) The performance and management of Commonwealth agencies and/or their agents or contractors in discharging their responsibilities associated with the detention and processing of irregular maritime arrivals or other persons;
- (j) The health, safety and wellbeing of employees of Commonwealth agencies and/or their agents or contractors in performing their duties relating to irregular maritime arrivals or other persons detained in the network;
- (k) The level, adequacy and effectiveness of reporting incidents and the response to incidents within the immigration detention network, including relevant policies, procedures, authorities and protocols;

ROLE CONFUSION REGARDING THE ROLE OF THE PSYCHOLOGIST IN THE MENTAL HEALTH TEAM

There was a great deal of role confusion within the mental health team and I stepped into the job without any orientation, introduction or even a job description. I asked my team leader and the "Psychological" Supervisor (who was trained as a mental health nurse before moving into administration) on a number of occasions in those early weeks, for some kind of help acclimatising to the role, however my requests were not answered. At one point I was asked to write the job description for the role as part of my time there. As it was a relatively short contract with intense working hours and work demands, I was keen to make the most of my time; however, much of my time early in the contract was spent very inefficiently, especially having had no formal handover from the previous psychologist.

Resources were stretched to capacity while working for the health service provider. Often there was not timely access to a computer to be able to type up session notes into the Chiron Database, and as the work was so unpredictable, it might have taken me a few days to finish typing in my notes. Finding a chair to sit on while at the computer was also another issue!

As far as clinical resources went, there were none. They did not have any type of formal assessment protocols or diagnostic tools for assessing mental illness. I was lucky that I brought a great deal of my own resources with me, which other members of the team began to use. I introduced the use of the PTSD Symptom Checklist, and other freely available, evidence based diagnostic tools and scales for depression, anxiety and stress. I also introduced the team to the website run by the Centre for Clinical Interventions (<http://www.cci.health.wa.gov.au/resources/consumers.cfm>), for use of their free resources with clients. Often we would need to alter it somewhat to make it culturally appropriate/relevant for each individual. I wanted to get many of the work sheets translated into all the various languages and distributed throughout the compounds, however my supervisors, fobbed me off. As I did not have the time or the money to take the idea any further alone, I would just continue to raise it with my superiors when I had the chance. Nothing eventuated while I was there. But after I left, a colleague from the mental health team said that he approached DIAC staff directly and asked for them to make translations of the psycho-education documents and distribute them among the compounds, without consulting the team leader or the Psychological supervisor. Proving that the only way to get action that benefits the detainee population is to act on it yourself.

From what I understood of what I was told by the Psychological supervisor (who was based in Sydney), I was expected to work as part of the mental health team and was to carry out the same work as the

mental health nurses. I was not expected to actually do any therapy, provide psychological treatment, or evaluate outcomes of such treatment (which, as a psychologist, is what I am trained to do). It became apparent that I was to only offer supportive counselling, and provide limited and brief treatment in response to diagnosable cases of Anxiety and Depression, and to cases that present any form of "RISK" in terms of suicide or self-harm. Any Torture or Trauma (T&T) issues that arose in the counselling session were to be handled by the Indian Ocean Territories Health Service (IOTHS), who had a team of counsellors (made up of a mental health nurse, a social worker, a counsellor, and a clinical psychologist) who were providing the Torture and Trauma counselling service.

I was even made to feel that seeing detainees for sessions that went for 50 minutes was too long, and I was not being productive and fast enough. Even though, session times of 50 minutes are a minimum standard when working with an adult population.

I found this to be extremely restrictive and limiting on my practice as a psychologist. It was also unethical and impractical for the detainees, considering the way people experience a mental illness, particularly something as all encompassing as Post Traumatic Stress Disorder (often which include symptoms of depression and anxiety). Put another way, it would have been negligent of me as a psychologist to have followed the advice of my supervisor and not treat PTSD if I saw it. Particularly as the waitlist for services from IOTHS and the logistics of obtaining those services created an almost impenetrable barrier for a detainee to receive timely and appropriate treatment for often quite serious mental health concerns. I felt from my training and experience I was more than qualified to begin initial assessment and the early stages of treatment for PTSD, and would do so while detainees were simultaneously on the waitlist for IOTHS services.

Unfortunately, no one else on the health service provider's mental health team was trained to treat PTSD, or even assess for its presentation. This meant that many detainees were missing out and, unless they were directly referred to me on the team, they were left languishing on the waitlist for the T&T service.

A CONFLICT OF INTEREST REGARDING WHO THE CLIENT IS?

Looking at the bigger picture, another systemic issue I found interfering with my work was the confusion over who was the client? In my experience as a psychologist (working in a variety of positions for the WA Dept of Health (in psychiatric hospital and community settings), Disabilities' Services Commission and other private educational institutions), the client is the person before me in the counselling room who trusts me to have his/her best interests in mind, while he/she pours out her suffering in a contained and safe environment that is the counselling session. The client is the individual who utilises the services of trained mental health professionals to address newly emerging or ongoing mental health problems. However, in my short experience working for the health service provider on Christmas Island, it was immediately and sometimes blatantly obvious that the vulnerable people I saw in the counselling rooms were not regarded as "the client" by my employer. To the health service provider, their "Client" was DIAC – the one who pays the bills.

This could be exemplified by the health service provider's rules restricting me (or any staff member for that matter) from engaging in direct discussions (client related or not) with any DIAC official, SERCO officer, or any other official or agency during working hours. There were two instances that I remember where a detainee had requested that I speak to his lawyer, simply to write a letter that "Client X" had been attending the mental health service for some time. On another occasion, a case manager was attempting to contact me regarding our shared "client", perhaps in an effort to ask me questions or notify me of his deteriorating condition, who knows. On both instances I was told directly by the Mental

Health Team Leader, the Psychological Supervisor and the Medical Team Leader, not to get involved with direct discussions with anyone not employed by the health service provider, and that I was not to provide these simple advocacy services for my "clients". I felt as though I was forced to play a double role, one where I can advocate for my client within the therapy room, but I am rendered voiceless on the outside, despite client consent being given and requested to work in tandem with the other members of the "clients" team (i.e., his case manager, his lawyer, and anyone else that may impact on the individual's mental well-being throughout his/her time in detention).

In any normal workplace, if a client has given consent for me to communicate with a third party, for his benefit, then I am more than happy to do so, as that is in the best interests of the "client" (in this case, the detainee).

This conflict of interest I believe is one of the fundamental problems contributing to poor mental health outcomes in Australia's immigration detention network (the other fundamental problem contributing to poor mental health outcomes in Australia's immigration detention network is that of the policy of mandatory, prolonged and indefinite detention in high security detention facilities in remote locations).

With the health service provider (a subsidiary company of an overseas medical insurance company) at the helm of providing medical and mental health services, they will continue to view DIAC as their client (their paying customer). I believe that it does not matter how much money, or how many caring, talented and highly trained health practitioners you enlist to work in the detention network, their efforts will continue to be undermined by the policies and operational procedures of a for-profit insurance company that is about doing the minimal amount of work for the most amount of money to make the biggest profit, with no transparency allowed. Even submitting this statement I am breaching the Terms and conditions of the contract I signed and risk litigation.

AN INAPPROPRIATE MODEL OF MENTAL HEALTH SERVICE

The mental health service operated on an appointment system and also on a walk-in basis meaning that anyone who felt they needed to see a mental health professional could come and wait in line and be seen as soon as possible. This system however only operated at the North West Point facility and I am not even sure if many of the detainee population were aware that mental health offered a walk-in clinic Monday to Friday. As far as I was aware, the Phosphate Hill medical centre only offered walk-in mental health services three afternoons a week, when it was open as a medical clinic. Detainees at Phosphate Hill and Alpha compounds had to put in a written request to Serco, who then had to send the request through to the health service provider, and then we contacted Serco to bring the client to the Medical centre when an appointment time was available. There was no way to communicate with the client to offer them a time that would suit them. Often clients are engaged in activities (albeit limited) throughout the week, and it made me uncomfortable to have to ask a Serco officer to bring a client to a mental health appointment, without any warning, and that could be interrupting an activity that may be vital to their well-being and ability to cope in detention.

It is just one illustration of the of the systems and operational procedures in immigration detention centres that act to strip away any sense of personal control (and self-sustainability), disempowering vulnerable detainees who have already requested mental health support, and may subtly have a further negative effect on their already unstable mental state.

It is a poor model of practice where mental health is offered on a walk-in basis – it means that we would often react only to people in crisis and often, at that point there is not a lot that a mental health worker can do but listen to a detainee explain how their world has fallen apart and their life is hanging by a

thread! It was difficult to encourage a detainee to make changes to their environment to better their mental health situation when the detainee and mental health staff member has very little control over the living standards and situations the detainee is facing every day. One of the most available and frequently used methods the mental health team would use was to put the client on suicide watch ("referred to as "SASH OBS" by staff at that time) with or without the client's consent. This would usually entail that (at that time) an untrained Serco officer was given responsibility to care for and accompany an acutely suicidal client through a very difficult time for the next 24 hours, at least. I would hear varying accounts of what kind of "care" the Serco officer would be able to offer. Some were very good at being a kind and beneficent presence that the person needed to shepherd them back to mental stability, while I's heard that others had just said "hello" every now and then and made sure they had not created a noose for themselves with their bed sheets while they were not looking. The constant monitoring of the "SASH OBS" intervention would often be perceived as punitive by the client, and (depending on which type of "care" was offered by the Serco officer) would sometimes increase a detainee's distress and paranoia about the situation they were in.

It seemed that the model of service was based on a model of mental health often applied to a psychiatric hospital setting. This is a setting where Patients have been admitted usually following a crisis and have been diagnosed with a psychiatric / mental illness and have usually had some experience with mental health services prior to being admitted. Also, under this model of service, rates of recovery from mental illness without long (or indefinite) courses of drug therapy are notoriously low. However, a detention centre is certainly not a psychiatric hospital and we were not providing a service for people who have been diagnosed with mental illness. By and large the majority of the detainee population were "normal" people, fleeing abnormal and horrific circumstances back home and were just doing the best they could to cope with whatever they were given. Many of whom were traumatised and experiencing symptoms of PTSD to varying degrees, and coping with their trauma to varying degrees. These people required a client- centred, preventative model of care, with community interventions, focussing on fostering and maintaining a sense of safety in the centre (where possible) and empowerment for the individual through both psychological treatment and institutional operations and procedures, so that it was a part of their everyday experience.

Incident reporting became a dirty business. No one wanted to be the one to have to report an incident, and as soon as an incident was apparent, the blame game quickly ensued. Also, due to my lack of orientation on policy, procedure, authorities and protocols, perhaps a great deal of incidents were not reported the way they should have been. I also did not understand the purpose of reporting incidents as no one else was able to deal with a person who had harmed themselves besides the people on the ground caring for the detainee. Who were we reporting to? Politicians in Canberra, who wanted to use the statistics for political reasons..? It did not seem to have any real bearing on improving the system or the care that was afforded to the detainee. I was appalled (though not surprised) to find that the first steps taken by the powers that be following the Christmas Island Immigration Detention Centre riots in 2010 was to sack staff. Did they think this was going to prevent more riots happening, as though you could blame the person at the end of the command chain. It was the Institution's operational and procedural policies that created an environment where detainees felt so totally disempowered that they

could lose respect, not just for the place where they hope to seek refuge, but even for their own life, that caused riots. Not individual staff.

I recently found this comment in a report on the ABC news website:

"TOM IGGULDEN: The Government says it too is concerned by the rate of self-harm in the detention network. A spokesman for the minister told Lateline, "The Immigration Department and the contracted health services provider ensure people in detention have access to mental health care, including mental health nurses, psychologists and psychiatrists. All personnel who work with people in detention are trained to recognise and respond to the warning signs and risk factors of self-harm.""

What the minister told Lateline is all very well but it does nothing to prevent detainees' acts of self-harm, only to recognise it when it is happening. A different approach is required to actually help people to cope in more functional and adaptive ways rather than harming themselves. However, this approach that I speak of is continually thwarted by the risk- management model that the health service provider operates under, a model selected as appropriate to the company as it is in line with their overriding concern to "protect their business". At some point in an effective psychological intervention, you need to move beyond responding to the immediate risks and actually deal with the problems that cause the self-harm. I think that if people are going to be incarcerated indefinitely without trial, we owe them that at the very least.

Lack of Time Allocated to the New Arrivals Procedure

I participated in a few new boat arrival intake assessments. The mental health assessments were not much more than a "meet and greet" mini mental state exam, and most of which was culturally inappropriate, we were also encouraged to complete the mental health assessment in less than 5 minutes (if possible) so that the new arrivals could be processed in the allotted time frame, otherwise (as I was told by a fellow staff member) the health service provider would be penalised financially for running late.

Lack of Consistency with the Three-Monthly Mental Health Check-ups

The three monthly mental health checks were designed to check up on detainees still in detention and complete a brief mental state exam. These often consisted of writing down a few words and checking globally "how are you coping?" However, the majority of scheduled three-monthly check ups were just not happening. Each day a list of names (with their ID numbers) would be posted up in each compound, with the assumption that the person on the list would be able to read his or her name (in English), and would then know that it was their day to come for a mental health check. No appointment times were given, just their name on a list, under "Mental Health". I felt this system was somewhat inadequate given the kind of population that we were providing a service for. Firstly, these people are not all literate; secondly, if they did not happen to see the list that day or that week, then they missed their appointment. Their name would keep appearing on the list for a week, and then the next batch of 3-monthly mental health checks would be circulated. I can imagine that seeing your name on a list under the title "Mental health" is not much of an invitation for someone to come and tell mental health how they are feeling and how they are coping. If anything it is stigmatizing and a violation of one's confidentiality.

Sometimes it would induce anxiety in the individual who was not expecting a 3 monthly check-up, whereby they see their name/ID number on a list and wonder what it is for, worrying that it could be about their asylum application (leading to either a visa or removal). Often, you would hear about "systems of luck" that would appear within the detention population. For example, a person may have gone to visit mental health, and then the following week happened to obtain his security clearance and

visa to Australia, the next day many more detainees would start requesting mental health support, in case they had the same luck. This is an illustration of the powerlessness and helplessness detainees experience on a prolonged daily basis, and the kind of magical thinking people resort to in these circumstances.

Again, while I was undertaking 3-monthly mental health checks, I was encouraged to be fast, so that the team could get through the back log. Sessions lasting 15 minutes were regarded as appropriate, regardless of what came up in the session. Should any indication for treatment be present, they were to be given an appointment to see someone from the team at another time. However, if mental health issues were a concern for the individual I would often use the appointment as a longer assessment consultation and begin assessment and treatment for the individual, if they agreed to it. While, it was not encouraged for me to act this way (if anything it was frowned upon, that I would spend that much time with a client), often many mental health issues were addressed and resolved in a much timelier manner. I also believe that I was helping to prevent potential incidents of self-harm and/or suicide, as a detainee's initial (seemingly low - no risk) mental health concerns were taken seriously and acted upon quickly. Although it would have been contrary to the advice from the Psychological Supervisor, who would remind me that the mental health service was primarily about risk-assessment, not treatment.

Eventually, after I had been on the team for a few weeks, a system developed (initiated by myself and other mental health team members – the team leader and Psychological supervisor had no hand in how this system operated) where I would take referrals from mental health nurses on the team, who felt that psychological intervention (delivered by a psychologist) was required. While this is typical of how a multidisciplinary team might work in any other health or mental health care setting in Australia, it was not encouraged by the health service provider's Psychological Supervisor.

It was tragic to see that there were no efforts to offer any mental health outreach programs what so ever. I tried in vain to establish a program where psycho-educational handouts could be distributed around compounds translated into the various languages that covered topics such as insomnia and sleep disturbance, depression, anxiety, mindfulness techniques and coping and resilience building. It never got off the ground. I repeatedly talked about the idea with my team leader and Psychology supervisor, only to be told, "Oh. Perhaps you should go and speak to this person", or "go and ask this person..." Nobody who worked for the health service provider in a superior position to myself wanted to hear new ideas on how we could better help people, or improve the culture within the detention centres. It appeared that they just wanted to take their orders from the top and make sure their own arses were covered, when the next crisis situation arose. When a crisis did inevitably arise, the administration of all organisations were very quick to point fingers and play the blame game, despite ignoring ideas on how to improve things and prevent issues arising in the first place.

I could see that "community oriented" interventions and an outreach style of mental health service was essential when working with the detainee youths and traumatized adult population (who have very limited appropriate internal resources to cope with their situation), and whom all are from a variety of different cultural back grounds – with their own cultural ideas about mental illness. In fact, many of the detainees that I spoke to reported that their culture do not even formally recognise "mental illness" or have a concept of "mental health" in the western sense of the word. In cultures where they did recognise the concept the level of stigma attached to it would be so prohibitive that accessing any kind of help for an individual's condition, let alone acknowledgement, would be very rare.

Given these factors, to rely on people to come forward when they feel they are suffering psychologically and need some kind of mental health support is absurd. In this system, people are expected to rely on

their own internal resources to cope with an unknown quantity of suffering. When a person reaches the limit of their ability to cope (as they inevitably do a mandatory prolonged and indefinite detention setting), suicide and self-harm become rational options for the individual in an effort to cope with the situation. To think that this kind of service (risk- reactionary) would actually be helpful in preventing and treating the majority of mental health problems that arise in detention settings is equally absurd. More often, a detainee's psychological suffering would initially present as a physical complaint and many detainees would present to medical services for assistance with a range of un-diagnosable physical complaints (most evidence in the PTSD literature will support this behaviour as indicative of PTSD). Often these cases would be treated with a bit of TLC (yes, tender loving care, was how one medical nurse spoke of it) and sent back to the compound. Or, if the medical centre was busy, they would be sent to the bottom of the triage list and often would not be seen at all, waiting around all day, just to be told to try again tomorrow (too bad if it was a Friday). Most of these cases would not be aware that their physical experience may be an indicator of a genuine mental health concern that required further assessment and monitoring by mental health staff, and so medical staff would not think to make the referral.

As I have experience working in the State health Department I would often draw comparisons and evaluate the model of practice operating on Christmas Island. It did not take long for it to become apparent to me that a vastly different model of care would be required in order to be more efficient and helpful in meeting the needs of this particularly vulnerable population.

DISORGANISATION WITHIN THE HEALTH SERVICE PROVIDER

At the time I was employed, the company was in a state of disarray. The payroll department made consistent errors with staff pay and almost no-one were paid what they were owed at the end of each fortnight.

Every fortnight here was another farcical story of how someone only got paid \$200, while another got paid \$20, 000. The staff based on Christmas Island were disgruntled about ongoing pay disputes, and that many people's contracts had not been renewed or updated. Staff were hanging in limbo for weeks as to whether they would be working there for another three months, and under what conditions.

During my time there was a visit to the island by the Ombudsmen and Detention Health Advisory Group, and some superficial efforts were made to paint a rosy picture and to "clean up the place" so that they could not observe how the place usually ran. For example, they cleaned off the white board usually used to record details of which clients were currently on suicide and self harm watch (SASH OBS), and hid away broken medical equipment. I have also spoken to some of the nurses who provided anecdotal evidence that much of the medical equipment in the health centre was inadequate, broken or obsolete. It was about portraying an image to the "client" (i.e. "DIAC") that the company had it under control and we were doing the best they could. I think that some of the staff were doing the best they could, with very little support or recognition for their efforts.

Most mental health team members were from an acute psychiatric background, working in psychiatric hospitals on locked and open wards. However, as noted above, I believe this model of practice is not suited to the needs of the client population residing indefinitely in an immigration detention facility. Only one mental health nurse had extended experience in providing counselling (from his work in an addictions centre).

When I left Christmas Island I was also unable to speak to my replacement as I was flying out on the plane he had arrived on. He was never given any contact details and just made it up as he went along,

like I had and like the many psychologists before me had done. It was like the company was deliberately keeping the previous psychologist from seeing the next one in case we passed on information the company did not want the new person to know about.

That the transition from one psychologist to another within the mental health team was not coordinated to allow for a proper clinical handover on repeated occasions, I think constitutes unprofessional and negligent practice on the part of the health service provider (negligent on the grounds that the transfer of care from one practitioner to another does not happen in a timely or appropriate way, if at all. It is very easy for clients to fall through the cracks and never be seen again. Unless, the individual has the personal resources to overcome the sense of abandonment by the service and self-refer to the service again or deteriorates to display some other form of maladaptive coping (acutely self-harm or suicide attempt) and manage to alert the attention of staff (only if their attempts were not fatal).

There was very little research or ongoing monitoring of the mental health of the detention population as a whole. It would have been helpful to have had access to databases and statistics on average length of stay, and the types of services detainees utilised whilst in detention. However, no one seemed to be looking for bigger picture patterns in detainee presentation, and any form of ongoing "case management" from a mental health perspective, was just not happening. I found that I wanted to start monitoring by way of formal psychological assessment, how people were thinking and feeling throughout their stay in detention, so that we could have some kind of objective, evidence based-map (relevant to this particular detention centre) to give new detainees some idea as to what they may experience, and to give staff the ability to plan ways of how to prevent things getting bad for them, by identifying appropriate courses of intervention.

Lack of communication between other relevant agencies (e.g., Serco, DIAC, IOTHS Torture and Trauma Counsellors) and a poor coordinated case management system

We were encouraged to work in a silo. The company guarded their information very carefully and securely, in an effort to protect their business. However, I often found this secrecy and lack of transparency was inhibitive on our role as the mental health service providers. We were unable to communicate directly with any DIAC or Serco staff member that had any dealings with a detainee who was using the mental health service. All lines of communication had to follow strict channels up the line of command and slowly, if ever, it got filtered back down the other side; hopefully to the person you wanted to speak to.

For example, I had many clients who were experiencing a worsening of anxiety symptoms usually as a result of not having heard any news from their case manager for over a month, and was becoming increasingly distressed. These symptoms often included (but were not limited to) chronic insomnia, lethargy, physical ill health (often a sign that the ongoing stress has begun to compromise immune system functioning) and reliance on other maladaptive coping strategies (such as inactivity, increased smoking, withdrawal from social interactions).

Obviously being able to communicate with the client's case manager and ask them to pay a visit to the client in question, providing the case manager with limited and relevant information regarding the client and the reason for their current condition (while obtaining the Client's consent prior to contact with the case manager), would be the fastest and most appropriate way to ease the client's distress. Unfortunately, as the system operated while I was working for the health service provider, if I wanted to communicate with a DIAC case manager (even though I was told not to do so by the Psychological Supervisor), I was to put something in writing, which was then sent to the medical centre manager,

which then went to Detention Health in Canberra (I presumed, and was what I perceived as some impenetrable hidden black box), who then vetted my communication, so that I did not breach any "client confidentiality" and then it eventually reached the case manager, who probably lived two doors down from me in the next apartment! We could've fixed things up and helped our mutual client (the detainee refugee) feel a lot better a lot sooner and we as employees would also have felt empowered to do our job as we would do normally in any other mainland government health setting. We would have alleviated unnecessary suffering that was a direct result of the detention experience (which could lead to PTSD for this client later down the track) and we may also have potentially avoided an incident where the client may have felt they had no option but to externalise their suffering through self-harm or suicide.

There was no coordinated case management system in place at the time I was there which may have actually put detainees' lives at risk. And even when organisational changes were being made - with the training in and implementation of the new mental health policy for immigration detention - my employer told me I was still not to communicate with any other agency (DIAC or Serco). My supervisor told me, in a private meeting following one of the training sessions, that the reason IHMS were not yet willing to follow suit with the other agencies was because, "we still don't know yet how the new policy is going to work operationally" (even though it was clearly spelled out in the policy documents, with regards to case conferences). Additionally, "we need to make sure that it is going to be in the best interest for our business". It was shocking that other stakeholders (i.e. Serco and DIAC) were ready to embrace the new mental health changes (that would have improved the daily lives of everyone working and living in the facility) except for the organisation that is to provide those mental health services.

Lack of access to appropriate professional supervision

I was refused professional supervision with leading psychologist on psychological problems in detention settings, Amanda Gordon. I certainly would have benefitted from some steady, and credible guidance from an experienced professional in this area with regard to clinical matters and managing my own issues in the counselling room (as at this point I think I was suffering some of the effects of burn-out and vicarious traumatisation), which I did not feel safe (or that it was appropriate) discussing with the Psychological Supervisor or the Mental Health Team leader).

Amanda was on the island providing training to the health service provider, Serco and DIAC staff on how to implement the new mental health in detention policy, and I believe it was the company who funded her. I have text messages saved on a mobile phone from [redacted] for the health service provider, which give their reasons why I was not to consult with Amanda with regards to professional supervision. The messages basically illustrate how the values of the business model supersede the value of the clients, their mental health and well-being. It is bureaucracy gone greedy, and it is the staff and detainees who suffer.

Text message transcript:

Message from [redacted]
"Yep mate if you want to see him [i.e. the complex client I had discussed with team leader], if you want clin. supervision from Amanda run it past [redacted] shouldn't be a problem"

Messages from [redacted]
"Unfortunately she is here to do training only, and we can't cross those barriers. If you have a complex client, you do need to discuss with [redacted] the team or myself. I know it is difficult because you may be

used to doing that with each Psychologist although here it is the multidisciplinary team and if they are a difficult client, the team need to know, whether it is a risk issue or some therapy.

"Finishing my text. It is something that you will have to embrace, working within this team. Even if there are three psychologists, you cannot work in isolation. Talk to me tomorrow if you need to. Again, we have myself and the whole team, please don't pressure. If you need further assistance that you don't think [redacted] the team or myself can provide, speak with the medical director with [redacted]. Amada is not here to provide any clinical assistance, she is under a strict business contract, if advice she provides is wrong and something happens, as a business we are at huge risk."

This is an uninterrupted stream of text messages. I had not replied at any point to these messages, and after receiving the final message I did not bother to reply at all. From these texts, it was very clear to me that business came before mental health care.. It was only a few days after this stream of texts that I was fired, asked to leave work immediately, and on a plane off the island three days later.

Why was I prohibited from consulting with Amanda for professional supervision? Even though the company had already paid for her to come to the island to work with mental health and other relevant Serco and DIAC staff on how to implement the new mental health in detention policy (ironic). We could not have asked for a more skilled clinician to help me at that particular moment with my professional dilemmas and the difficult client I was working with. Supervision is a normal, and in some workplaces a required, part of working as a psychologist. In fact, it is common practice that when clinical supervision is not provided by the company or employer (as is often in most cases), a psychologist will arrange for their own external supervision to be provided by a psychologist outside their workplace. All practicing psychologists take their professional ethical code of client confidentiality very seriously.

THE ISSUE OF "DETENTION SYNDROME" AND PTSD IN A DETENTION ENVIRONMENT

After completing a number of boat arrival mental health checks, and three-monthly check-ups and meeting detainees who had been in detention for time periods from one day to 12 months, I began to see a similarity in presentations emerging which I called at the time "caged (traumatized) human syndrome" or "detention syndrome".

Initially, when a detainee had first arrived on Christmas Island, 100% of people I spoke to were extremely relieved to be on dry land, and feel very grateful to be alive and extremely appreciative to the Australian navy and government for picking them and allowing them to make their claims for asylum. Many people are feeling optimistic about their futures, that they managed to escape their war-torn homelands and had completed their long, dangerous and arduous journey to finally arrive at a safe haven. Or so they thought. This feeling typically lasted anywhere from the date of arrival and up to approximately four or five months of detention. After about 6 months in detention many detainees are starting to show signs of the detention syndrome (this is a very conservative estimate, for many symptoms might appear a lot sooner, depending on what sort of contact they have had with the outside and when they last saw their family (if they still had any family left)). The syndrome is basically a wearing down of the person as they are exposed to constant stressors, for which they have not been able to adapt to or control their environment to prevent. For example, detainees would often report their inability to cope with issues of lack of sleep and insomnia; overcrowding and competition for limited resources (long queues for meals, telephones, computers and activities); uncertainty over future events and the situation of 'indefinite detention; limited privacy or quiet time to unwind; inability to take care of one's self and be self reliant/independent; have no occupational outlets or work to do; being out one's usual context (personally and culturally) and a lack of skills for coping in a detention environment.

I observed there was a cluster of similar symptoms that people experienced regardless of their country of origin, race and cultural background, and whether or not they had experienced trauma or exhibited signs of PTSD. The detention syndrome would often be secondary to other more pressing mental health concerns for most detainees who would present for help, except for the people who had been in detention for periods longer than 6 months. There were several cases where detainees had been relatively healthy and happy (some of whom had been detained for over 9 months and still uncertain as to their visa situation) could then, all of a sudden, present to the mental health clinic and report feeling acutely depressed and suicidal. Some of the common symptoms I noticed were:

Chronic sleep disturbances (Insomnia, over sleeping, vivid dreams and nightmares); Shame; Self-blame; Subjugation; irritability and anger problems; Morbid hatred; Paradoxical gratitude (towards those responsible for their prolonged and indefinite incarceration); Resignation, with markedly diminished interest in past or future.

It was particularly heart breaking to see young men in the prime of their lives, be overcome by these symptoms. That despite all they had gone through to escape persecution from their home country to then arrive in Australia and not be able to imagine a future for themselves anywhere. Managing the syndrome is like managing a steep ascent on a mountain to which there is no peak, just climbing, until the day they have no more energy (physical and mental) or they are released from detention.

Why there are riots and disturbances in detention facilities

Based on my experience training and working as a Psychologist and Clinical Psychologist for the past six years, and more recently on Christmas Island with the population of asylum seekers, I feel it would be conservative to estimate that at least half of asylum seekers to Australia (given their history, country of origin and method of arrival to Australia) would have experienced/witnessed trauma to themselves/others (both recently and in the past) to a degree that would lead to symptoms severe enough that would warrant a diagnosis of moderate-severe PTSD. It would also be a conservative estimate that 95% of asylum seekers to Australia would have experienced/witnessed trauma to themselves/others (both recently and in the past), however, for individual reasons have enough personal resilience and coping ability that their symptoms would warrant a diagnosis of only mild PTSD, if any diagnosis at all.

Managing symptoms of an illness such as PTSD while living in a highly stressful environment that is mandatory detention, combined with a lack of adequate mental health services on offer, all contribute to a toxic (and often hostile) environment for staff and detainees alike. Where it is no wonder that outbreaks of violence and self harm behaviours (among detainees) and intra / inter-departmental conflict and burnout (among staff) are so common in these situations – as these are simply the instinctive human survival responses to a situation in which we are given very little (if any) preparation or skills to survive in.

The prevailing symptom of Hypervigilance (the sub-threshold arousal of the sympathetic nervous system and a decreased accessibility of the frontal lobes and our capacity of executive/rational thought) combined with a highly stressful environment would make anyone highly sensitive to any perceived threats of harm to oneself (whether realistic or not), and would likely lead a person to take whatever means necessary to survive that perceived threat. The sympathetic nervous system would react automatically to such perceived threats and thrust an individual into an acute stress response (commonly known as the 'fight/flight' response). While individuals respond differently to threats in different situations (eg, difference between males and females) it is generally accepted on a basic level

that if an individual cannot escape a situation in which there is a perceived threat, fighting (i.e., the fight for survival) becomes the automatic natural response.

CONCLUSION

My time working on Christmas island has left a deep scar and there remains a dark cloud in my mind, that I believe still contributes to the difficulties I have in my life now (the burn-out I experienced on the job, I believe was likely to have contributed to the post-natal distress I experienced following the birth of my son, nine months later).

The conditions I worked in were less than optimal and at times negligent. When those who work on the coal face, directly with the clients on a daily basis, begin to feel just as disempowered as their clients a toxic and hostile work environment begins to emerge. And disempowered and depressed workforce does not make for effective mental health interventions. This is dangerous workplace policy that puts every client at risk, as at that time, there was only one psychologist and 5 mental health nurses employed to be available for the 1800 or more clients in CI detention facilities. This is far below the staff/client ratio at any of Australia's major psychiatric institutions.

I know the APS has also made a submission to the Joint committee with concerns about the way IHMS are delivering their medical and mental health services. After attending his talk, I am also aware that the 2010 Australian of the Year Prof. Patrick McGorry also shares my view that tendering out vital services such as mental health to private organisations that operate under a for-profit business model and lack any kind of transparency in their practices, is the wrong way to ensure Australia will see better mental health outcomes for this most vulnerable population. The company providing the health services to Australia's detention network play by their own rules, and will not necessarily do what they are told, just because DIAC or anyone tells them to. They are not accountable to anyone, they do not have to follow "best practice" guidelines, and they will always put the safety of their business venture first, before the wellbeing of any staff member, client or detainee. And, as far as I am aware, there is no other competitor in the market for the tender to provide mental health services to Australia's immigration detention network. If these guys are our only external option, then this is a dire state of affairs.

I feel Australia needs to take greater responsibility and immediate action for the welfare of their people, as 90% of people making an application for asylum on our shores are accepted as genuine refugees, and later given protection and permanent residence of our nation.

Based on my training, education and experiences being involved directly with the delivery of mental health services within the Christmas Island Detention centres I make the following recommendations.

RECOMMENDATIONS

- End all policies that allow the mandatory, prolonged, indefinite detention for any person seeking asylum in Australia or elsewhere.

If this is should not happen immediately, then the following steps need to be taken as soon as possible:

- End the practice of outsourcing the security, detention, medical and mental health services to any private for-profit corporations. These should be provided by the Australian government with all expected levels and assurances of transparency in any other government organisation that is responsible for a vital public service.

- A thorough audit of all the health service provider's finances, resources and materials should be launched as part of the Joint Select Committee's investigation, to see how much of a profit they (and Serco for that matter) are making as a result of Australia's Detention Network, and how they are going about servicing the medical and mental health needs of detainees, with regards to the timeliness and appropriateness of the service.
- Ensure the availability of suitably trained staff to respond to, treat and prevent mental health issues that arise in the detention setting
- Ensure the provision of treatment for mental health problems (particularly in instances where a detainee has already requested help) in a timely and appropriate way, according to best practice guidelines.
- Develop a more integrated mental health care model. One that would be much more efficient and helpful in meeting the needs of the client population. The service provided by IHMS inside Australia's detention network, in no way reflects the complexity of the mental health service system available to the Australian people, and is far from being a "comparable service". What I believe is needed is outlined below:
 - Immediate consultation with experienced psychologists is required so that a better model of care can be developed.
 - Appropriate planned outreach and community level interventions are required where better mental health initiatives need to be integrated into the daily life of a detainee. For example, some simple and inexpensive ideas I had (and suggested to management, and had laughed at) while working on Christmas Island included – offering mindfulness and mediation classes every morning in the gymnasium; staging "compound competitions", where one compound competes against another in different activities (such as; soccer, cricket, paper aeroplane designing and throwing); Art therapy, and exhibitions of detainee art; developing better channels of communication between DIAC, the health service provider, SERCO and detainees, by way of a printed weekly news bulletin (available in translated versions), so that detainees are informed and reminded of the services and activities available to them and the efforts made to process them as quickly as possible and to help them cope better with their stay in detention).
 - As part of the new model of care, a "detainee-centred" approach is established, whereby the well-being and mental health care needs of the detainee are put first with regards to how a detainee is cared for by all staff and agencies working within Australia's Immigration Detention network.
- Provide better access to interpreters to help those who are illiterate, and in the delivery of vital services.
- And again, stop outsourcing essential services such as (medical and mental health) to private, for-profit companies.