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Deciphering despair:

A study of self-harm in the Australian asylum seeker population

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Centre for Mental Health, Melbourne School of Population and Global Health

The University of Melbourne

Abstract

Australia has had a policy of mandatory immigration detention for all 'unlawful non-citizens' since 1992. During periods when there have been a large number of boat arrivals, the vast majority of the detention population have been asylum seekers, referred to as 'irregular maritime arrivals'. Whilst asylum seekers are at elevated risk of self-harm, and being detained is known to further increase such risk, until recently little has been known about self-harm across the Australian asylum seeker population. This is largely due to the lack of accessible data, and the Australian immigration authorities' poor self-harm monitoring and reporting processes.

This thesis fills a number of gaps in both the national and international literature. It comprises a review of the literature, undertaken in context of the policies governing Australia's treatment of asylum seekers, and four discrete studies. The evidence generated in the production of this thesis sheds revealing light on Australia's self-harm monitoring and reporting practices among asylum seekers, as well as the episode rates and key characteristics of self-harm, across the entire Australian asylum seeker population (including by processing arrangements, i.e., onshore detention, offshore detention [Nauru, Manus Island], community detention, and community-based arrangements).

The findings reported in this thesis indicate that Australia's self-harm monitoring and reporting practices are substandard and inconsistent when assessed against international guidelines; and that the burden of self-harm across the Australian asylum seeker population is substantial, particularly among detained asylum seekers. The findings also indicate that episode rates of self-harm are markedly high across all three main types of onshore immigration detention, in comparison with the general population, with average rates not observed to be lower in facilities with lower security features. Variations in the distribution of self-harm were also found according to time of day and month of the year, by processing

arrangements. Moreover, high rates of attempted hanging were observed among those in closed immigration detention, compared with community-based settings, as well as in all three main types of onshore detention, and in both males and females. When taken together, the findings reported across the studies included in this thesis make a compelling argument for the expansion of community-based models for processing; tailored, culturally appropriate mental health services for asylum seekers, and the implementation of independent monitoring and reporting of self-harm by a panel of clinical experts who have the statutory power to investigate self-harm among asylum seekers. Targeted, evidence-based responses such as these are likely to contribute to improved mental health outcomes for asylum seekers, and should therefore be considered an urgent public health priority.

Declaration

This is to certify that:

i. This thesis comprises only my original work towards the Doctor of Philosophy (PhD) except where indicated in the Preface;

ii. Due acknowledgement has been made in the text to all other material used; and

iii. This thesis is fewer than 100,000 words in length, exclusive of all tables, maps, bibliographies, and appendices.

Kyli Hedrick

Preface

This thesis contains four original research studies, as well as one commentary style piece – five published articles in total – all of which were completed during the course of my PhD candidature. I was the primary author for each of the five articles, and as such I was responsible for study conceptualisation, design, planning, statistical analysis, draft writing, and critically reviewing content. For all studies in this thesis, I was responsible for 100% of data collection, 95% of statistical analysis, over 85% of the study design and interpretation of results, and writing the initial drafts of all papers. My supervisors Dr. Rohan Borschmann, Dr. Gregory Armstrong, and Mr. Guy Coffey provided guidance in regards to the study design and development, as well as feedback and edits in relation to the study findings and overall synthesis of the results. None of the work towards the thesis was submitted for other qualifications or carried out prior to enrolment in the degree. No third-party editorial assistance was provided in the preparation of the thesis. Funding was provided by an Australian Government Post-Graduate Training Program Scholarship. Additional funding for publication costs was provided by Dr. Rohan Borschmann. The contributions of my supervisors and co-authors to each of the studies are outlined in further detail below.

Chapter 1 provides a brief introduction to this thesis. The introduction includes a short background to the subject matter and study context, as well as an outline of the main aims. This chapter also contains a short introduction to the PhD candidate.

Chapter 2 provides an historical background to the current research. More specifically, it outlines a condensed summary of the main pieces of international and national law governing Australian immigration policy since the introduction of mandatory immigration detention in 1992. The chapter also provides a brief outline of the main types of onshore immigration detention and community-based arrangements, as well the five main Australian asylum

seeker populations during the study period. I conducted the review and wrote the draft of the chapter. My supervisors provided comments to refine the chapter.

Chapter 3 provides an overview of the literature on the mental health of asylum seekers, in both detained and community-based settings. I conducted the literature review and wrote the draft. My supervisors provided feedback and edits to refine the review.

Chapter 4 provides a broad overview of self-harm, including the definition used in this thesis, common risk factors, motivations and functions, as well as costs associated with self-harm. It also outlines what is currently known about self-harm in asylum seekers. I conducted the literature search and wrote the review. My supervisors provided feedback to refine the review.

Chapter 5 introduces the self-harm dataset I developed for this thesis, based on Freedom of Information requests, and provides an overview of the methods. I wrote the draft and my supervisors provided comments to refine the chapter.

Chapter 6 contains Study 1, an evaluation of the quality of self-harm incident reporting across the Australian asylum seeker population, according to the World Health Organization (WHO)'s self-harm reporting guidelines. I designed this study in conjunction with Dr. Gregory Armstrong, and with support from my supervisory team. I conducted the statistical analysis, and drafted the initial manuscript. My supervisors provided feedback and edits to refine the draft. This study was published by *BMC Psychiatry* on 15 June 2020.

Chapter 7 comprises Study 2, an examination of the episode rates and characteristics of self-harm across the Australian asylum seeker population. I designed this study, with support from my supervisors, conducted the statistical analysis, and drafted the initial manuscript. My supervisors provided comments and edits to refine the manuscript draft. This study was published by *Social Science and Medicine – Population Health* on 15 July 2019. Chapter 7

also contains a commentary style piece written about the findings of Study 1, as well as our recommendations regarding an informed government response to this public health matter, published in *The Lancet Public Health* on 1 December 2019. I wrote the manuscript draft and my supervisors Dr. Gregory Armstrong and Dr. Rohan Borschmann provided comments to refine the manuscript.

Chapter 8 contains Study 3, an investigation into how episode rates and method(s) of self-harm in the Australian onshore immigration detention network vary according to held (or closed) detention type. I designed this study, with guidance from my supervisors, conducted the statistical analysis, and drafted the initial manuscript. My supervisors provided feedback and edits to refine the manuscript. This study was published in the journal *BMC Public Health* on 30 April 2020.

Chapter 9 consists of Study 4, an examination of the temporal variations in the distribution of self-harm episodes and method(s) used across the Australian asylum seeker population. I designed this study with guidance from my supervisors. I conducted the statistical analysis, and drafted the initial manuscript. My supervisors provided comments and edits to refine the manuscript draft. This paper was published by the journal *PLOS Medicine* on 6 August 2020.

Chapter 10 consolidates the major research findings, and discusses the broader implications for practice and policy. The chapter also outlines the study limitations and strengths, as well as areas for future research.

Publications arising from this thesis

1. **Hedrick, K**., Armstrong, G., Coffey, G., & Borschmann, R. (2020). An evaluation of the quality of self-harm incident reporting across the Australian asylum seeker population according to World Health Organization (WHO) guidelines. *BMC Psychiatry, 20*(1), 301. doi:10.1186/s12888-020-02709-7
2. **Hedrick, K**., Armstrong, G., Coffey, G., & Borschmann, R. (2019). Self-harm in the Australian asylum seeker population: A national records-based study. *SSM - Population Health, 8*, 100452. doi:10.1016/j.ssmph.2019.100452
3. **Hedrick, K**., Armstrong, G., & Borschmann, R. (2019). Self-harm among asylum seekers in Australian immigration detention. *Lancet Public Health, 4*(12), e604. doi:10.1016/s2468-2667(19)30221-x
4. **Hedrick, K**., Armstrong, G., Coffey, G., & Borschmann, R. (2020). Self-harm among asylum seekers in Australian onshore immigration detention: How incidence rates vary by held detention type. *BMC Public Health, 20*(1), 592. doi:10.1186/s12889-020-08717-2
5. **Hedrick, K**., Armstrong, G., Coffey, G., & Borschmann, R. (2020). Temporal variations in the distribution of self-harm episodes and methods across the Australian asylum seeker population: An observational study. *PLOS Medicine, 17*(8), e1003235. doi:10.1371/journal.pmed.1003235

Conference and seminar presentations

The results of this thesis have also been presented at the following local, national and international conferences:

1. **Hedrick, K**. (2020). Accessing unseen archives: Using the Freedom of Information Act in asylum seeker research. Oral presentation. The 8th International Conference of Community Psychology; June 26-28, Melbourne, Australia. (Accepted abstract; conference cancelled due to Covid-19. To be rescheduled to an online event).
2. **Hedrick, K**., Borschmann, R., Armstrong, G., & Coffey, G. (2019). No Alternative: Self-harm in the onshore immigration detention network, by held detention type. Poster presentation. The 2nd Australia and New Zealand Refugee Trauma Recovery in Resettlement Conference; March 27-29, Brisbane, Australia.
3. **Hedrick, K**. (2018). Self-harm among asylum seekers detained in Australia. Invited seminar presentation. Challenging Migrant Detention: Human Rights, Advocacy and Mental Health Conference; June 19-21, Montreal, Canada.
4. **Hedrick, K**., Borschmann, R., Armstrong, G., & Coffey, G. (2018). Kept at harm's length?: A mixed methods study of the incidence and characteristics of self-harm in the Australian asylum seeker population. Oral presentation. Challenging Migrant Detention: Human Rights, Advocacy and Mental Health Conference; June 19-21, Montreal, Canada.
5. **Hedrick, K**. (2017). Deciphering despair: A study of self-harm among asylum seekers. Oral presentation. The 1st Refugee Trauma Recovery in Resettlement Conference; March 29-31, Sydney, Australia.
6. **Hedrick, K**. (2017). Deciphering despair: A study of self-harm among asylum seekers. Oral presentation. PhD Program in Forced Migration and Refugee Studies Workshop; August 11, Melbourne, Australia.

7. **Hedrick, K**. (2016). An analysis of characteristics associated with self-harm among asylum seekers in Australian immigration detention. Oral presentation. Victoria University Research Conference; June 6, Melbourne, Australia.

Other related articles and conference presentations that I contributed to over the course of my PhD include:

1. **Hedrick, K**., & Borschmann, R. (2020a). Addressing self-harm among detained asylum seekers during the COVID-19 pandemic. *The Australian and New Zealand Journal of Public Health*, *45*(1), 80. doi/10.1111/1753-6405.13061

2. Hedrick, K., & Borschmann, R. (2020b, October 8). Self-harm in immigration detention has risen sharply. Here are six ways to address this health crisis. *The Conversation*. Retrieved from https://theconversation.com/self-harm-in-immigration-detention-has-risen-sharply-here-are-6-ways-to-address-this-health-crisis-146679

3. **Hedrick, K**. (2017). Getting out of (self-) harm's way: An examination of factors associated with self-harm among asylum seekers in Australian immigration detention. *Journal of Forensic and Legal Medicine, 43,* 89-93.
4. **Hedrick, K**. (2019). Managing the mental health needs of asylum seekers following cuts to SRSS: A view from private practice. Oral presentation. The 2nd Australia and New Zealand Refugee Trauma Recovery in Resettlement Conference; March 27-29, Brisbane, Australia.
5. **Hedrick, K**. (2017). Working with people from refugee and asylum-seeking backgrounds: A counsellor's tool box. A Masters of Counselling seminar, Monash University; June 7, Melbourne, Australia.

Research impact and public engagement

The findings generated in the production of this thesis have been cited in the following reports and submissions related to policy development and implementation in Australia:

1. The Australian OPCAT Network. (2020). *The implementation of OPCAT in Australia. Submission to the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT)*. Retrieved from https://www.kaldorcentre.unsw.edu.au/sites/default/files/Implementation_of_OPCAT_in_Australia.pdf

2. The Australian OPCAT Network. (2020). *The implementation of OPCAT in Australia. Submission to the United Nations Working Group on Arbitrary Detention (WGAD)*. Retrieved from https://www.kaldorcentre.unsw.edu.au/sites/default/files/Implementation_of_OPCAT_in_Australia.pdf

3. Peterie, M. (2020). *Submission to Senate Standing Committee on Legal and Constitutional Affairs, Migration Amendment (Prohibiting Items in Immigration Detention Facilities) Bill 2020*. Retrieved from https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/ProhibitedItems/Submissions

4. Kaldor Centre for International Refugee Law. (2020). *Submission to Senate Standing Committee on Legal and Constitutional Affairs, Migration Amendment (Prohibiting Items in Immigration Detention Facilities) Bill 2020*. Retrieved from https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/ProhibitedItems/Submissions

5. Amnesty International Australia. (2019). *Submission to the Australian Human Rights Commission: Free and Equal: An Australian Conversation on Human Rights*. Retrieved from: https://www.amnesty.org.au/wp-content/uploads/2019/11/AIA-Submission_AHRC-Free-and-Equal.pdf

6. Coffey, G. (2019*). Submission to the Royal Commission into Victoria's Mental Health System.* Retrieved from https://rcvmhs.vic.gov.au/submissions

7. Scoullar, K. (2019). *Witness Statement of Kylie Scoullar, General Manager of the Victorian Foundation for Survivors of Torture, for the Royal Commission into Victoria's Mental Health System*. *Appended material*. Retrieved from https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/4015/6350/6322/Kylie_Scoullar.pdf

Media coverage and mentions of PhD research

Some of the main findings of this PhD have been reported in both national and international media. Selected examples of media coverage include:

Radio

1. Robinson-Drawbridge, B. (Presenter). (2019, October 25). Self-harm rates on Nauru, Manus, 'exceptionally high'. *Radio New Zealand Pacific News*. Retrieved from https://www.rnz.co.nz/international/pacific-news/401747/self-harm-rates-on-nauru-manus-island-exceptionally-high

Print and online media

1. Santow, E. (2020, July 2). A blanket ban on mobile phones in immigration detention would be unacceptable. *Australian Human Rights Commission. Opinion.* Retrieved from https://humanrights.gov.au/about/news/opinions/blanket-bans-would-be-unacceptable?utm_source=miragenews&utm_medium=miragenews&utm_campaign=news

2. Trounson, A. (2020, June 19). Australia's sub-standard reporting of refugee self-harm incidents. *Pursuit*. https://pursuit.unimelb.edu.au/articles/australia-s-sub-standard-reporting-of-refugee-self-harm-incidents

3. Mirage News. (2020, June 19). Reporting on asylum seeker self-harm not in line with WHO standards: report claims. *Education News*. Retrieved from https://www.miragenews.com/reporting-on-asylum-seeker-self-harm-not-in-line-with-who-standards-report-claims/

4. Walden, Max. (2019, October 14). Asylum seekers in detention 200 times more likely to commit self-harm than Australians, research finds. *ABC News*. Retrieved from

https://www.abc.net.au/news/2019-10-14/asylum-seekers-in-detention-200-more-likely-to-commit-self-harm/11600148

5. Evlin, L. (2019, October 14). Asylum seekers at higher risk of self-harm if held in detention, study shows. *SBS News*. Retrieved from https://www.sbs.com.au/news/asylum-seekers-at-higher-risk-of-self-harm-if-held-in-detention-study-shows

6. Mirage News (2019, October 14). High self-harm rates among detained asylum seekers prompt calls for action. *Education News*. Retrieved from https://www.miragenews.com/high-self-harm-rates-among-detained-asylum-seekers-prompts-calls-for-action/

7. Phys.org (2019, October 15). High self-harm rates among detained asylum seekers prompt calls for action. *Social Science News*. Retrieved from https://phys.org/news/2019-10-high-self-harm-detained-asylum-seekers.html

eNewsletters and blogs

1. Forced Migration Current Awareness. (2020, July 5). *Thematic focus: Detention*. Retrieved from https://fm-cab.blogspot.com/2020/07/thematic-focus-detention.html?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed:+ForcedMigrationCurrentAwareness+(Forced+Migration+Current+Awareness+Blog)

2. Asylum Insight. (2020, July 1). *Monthly wrap. In research*. Retrieved from https://www.asyluminsight.com/round-ups/#.XwazwCgzbb0

3. Andrew and Renata Kaldor Centre for International Law. (2020, June 22). *Weekly news roundup. Refugees and asylum seekers in detention in Australia*. Retrieved from https://mailchi.mp/unsw/test-subject-1227872?e=5a78a6feea

4. Cabrini Health (2020, June 19). Self-harm in the Australian asylum seeker population. *Cabrini outreach news*. Retrieved from https://www.cabrinioutreach.com.au/news/self-harm-in-the-australian-asylum-seeker-population/

5. Asylum Insight. (2020, May 5). *Monthly wrap*. *In research.* Retrieved from https://www.asyluminsight.com/round-ups/#.XwazwCgzbb0

6. Forced Migration Current Awareness. (2020, May 5). *Thematic focus: Detention*. Retrieved from https://fm-cab.blogspot.com/2020/05/thematic-focus-detention.html?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed:+ForcedMigrationCurrentAwareness+(Forced+Migration+Current+Awareness+Blog)

7. Andrew and Renata Kaldor Centre for International Law. (2019, October 21). *Weekly news roundup*. *Australian asylum policy*. Retrieved from https://mailchi.mp/unsw/test-subject-1227567?e=5a78a6feea

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Last – though certainly not least – thank you to my friends and family, especially my sister, Renata, and Mum, Iris. For my father, **Claude Hedrick**, whose lifetime of work alongside people from refugee and migrant backgrounds has inspired my own: ***this is for you*.**

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Citation information for third party copyright material	Location of item in thesis	Permission granted Y/N
Map of Australia's operational immigration detention facilities by the Department of Immigration and Border Protection, 2015, https://reliefweb.int/sites/reliefweb.int/files/resources/map-of-operational-facilities-jan2015.pdf. This file is licensed under the Creative Commons Attribution 3.0 Unported license.	p.6	Y
Location of the Australian-run offshore detention facilities in Nauru, and in Manus Island, PNG, their distance from the Australian mainland, and details regarding their climate, 2015, by news.com.au, https://i0.wp.com/www.refugeeaction.org.au/wp-content/uploads/2015/12/nauru-manus-map.jpg. This file is licensed under the Creative Commons Attribution 3.0 Unported license.	p.7	Y

Abbreviations

AHRC	Australian Human Rights Commission
AMA	Australian Medical Association
ANAO	Australian National Audit Office
APODs	Alternative Places of Detention
AS	Asylum Seeker
BVE	Bridging Visa (E)
CD	Community Detention
DHA	Department of Home Affairs
DIAC	Department of Immigration and Citizenship
DIBP	Department of Immigration and Border Protection
ED	Emergency Department
FASSTT	Forum for Services to Survivors of Torture and Trauma
FOI	Freedom of Information
ICD-10	WHO International Classification of Diseases Tenth Revision
IDC	Immigration Detention Centre
IDF	Immigration Detention Facilities
IDN	Immigration Detention Network
IHMS	International Health and Medical Services
IMA	Irregular Maritime Arrival
IRH	Immigration Residential Housing
ITA	Immigration Transit Accommodation
Medevac	Medical evacuation (or air ambulance)
NGO	Non-Government Organisation
PPV	Permanent Protection Visa
PTSD	Post-traumatic Stress Disorder
RANZCP	Royal Australian and New Zealand College of Psychiatrists

RCOA	Refugee Council of Australia
SH	Self-harm
SHEV	Safe Haven Enterprise Visa
TPV	Temporary Protection Visa
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

Will you please observe through the wire
I am sewing my feet together
They have walked about as far
as they ever need to go.

Will you further observe
through the wire
I am sewing my heart together
It is now so full of
the ashes of my days
it will not hold any more.

Through the wire
one last time
please observe
I am sewing my lips together
that which you are denying us
we should never have
had to ask for.

Mehmet al Assad, Baxter Detention Centre, 2002.

Chapter 1: Introduction

1.1 Background

Australia has had a policy of mandatory immigration detention for all 'unlawful non-citizens' since 1992 (Phillips, 2015). During periods when there were large numbers of asylum seekers arriving by boat, the vast majority of the detained population were asylum seekers (Phillips & Spinks, 2013). Offshore processing was subsequently adopted and maintained by successive Australian governments between 2001-2008, before being dismantled in 2008, and recommenced in 2012 (Phillips & Spinks, 2013). From 2012, asylum seekers who arrived by boat without valid documentation were transferred to Manus Island in Papua New Guinea (PNG), or to the Pacific island nation of Nauru for processing (Karlsen & Phillips, 2014). National and international attention regarding Australia's immigration policies and their impact on asylum seekers' mental health has intensified since this time (Australian Human Rights Commission [AHRC], 2017).

It is now well-documented across several different cohorts and timeframes that asylum seekers have rates of depression, anxiety, and post-traumatic stress disorder (PTSD) that are many times higher than in the general community (von Werthern, Robjant, Chui, Schon, Ottisova, Mason, & Katona, 2018). Research also indicates that asylum seekers may possess several risk factors for self-harm, including previous traumatic experiences, social isolation, and poor mental health (due to pre-migration trauma, and post-migration stressors) (von Werthern et al., 2018), with detention found to increase such risk (Hawton, Linsell, Adenjii, Sariaslan, & Fazel, 2013). In addition to this, the mental health of asylum seekers has been observed to deteriorate with length of detention (Green & Eager, 2010). Despite the increased mental health risk for asylum seekers, Australia continues to detain asylum seekers in immigration detention. However, research regarding the rates and key characteristics of self-

harm among asylum seekers has been limited, mainly due to the lack of accessible information.

The paucity of research regarding self-harm among the Australian asylum seeker population is mainly attributable to the poor self-harm surveillance processes of the Australian government (Hedrick, 2017). The government does collect data on all self-harm incidents that are reported across the Australian asylum seeker population, and some data are made available under certain circumstances, such as parliamentary inquiries (Commonwealth Immigration Ombudsman, 2013). However, it appears that the immigration authorities do not routinely monitor, compile, analyse and report such data, and therefore cannot use these data to improve efforts to prevent and respond to incidents of self-harm. A number of parliamentary and independent reports (Australian National Audit Office [ANAO], 2017; Joint Select Committee on Australia's Immigration Detention Network, 2012; Legal and Constitutional Affairs Reference Committee, 2017) corroborate this state of affairs, citing problems with the Department of Immigration's information management and reporting processes, as well as the lack of independent monitoring of their self-harm reporting practices.

The costs of self-harm for individuals, families and at the public health level are extensive, and may be compounded over time and with subsequent episodes (Sinclair, Gray, Rivero-Arias, Saunders, & Hawton, 2011). Given such evidence, gaining a greater awareness of the epidemiology of self-harm in asylum seekers would seem imperative, in order to aid those in government, as well as public health experts, and allied health professionals, with the planning and management of self-harm (World Health Organization [WHO], 2014). Research regarding the episode rates and key characteristics of self-harm is consequently essential for informing the evidence-based treatment and prevention of self-harm across the entire Australian asylum seeker population.

1.2 Study context: The Australian asylum seeker population

Since late 2012, there have been five main Australian asylum seeker populations, which can be categorised according to processing arrangements: (a) community-based asylum seekers; (b) those who are held in community detention; (c) those held in onshore immigration detention (which includes centres on the Australian mainland as well as on Christmas Island, a remote island located in the Indian Ocean); (d) those who are held in offshore immigration detention on Nauru and; (e) those held in offshore immigration detention on Manus Island.

During the 12-month study period, 1 August 2014 to 31 July 2015, all 'unlawful non-citizens' held on Nauru and Manus Island were asylum seekers, referred to as 'irregular maritime arrivals' (IMAs), or those (comprised of a comparatively smaller group) found to be owed refugee protection (Department of Immigration and Border Protection [DIBP], 2015a). The vast majority of individuals held in community detention, as well as in community-based arrangements at this time were also asylum seekers, the latter commonly referred to as the 'legacy caseload' (AHRC, 2019a; DIBP, 2015a). Whilst the majority of those in onshore immigration detention during the study period were asylum seekers, or IMAs (accounting for at least 70% of the entire population – the average annual composition of the population was 70% IMAs, 2.4% air arrivals, 12.2% visa cancellations, 17.3% overstayers, 0.1% seaport arrivals, and 0.02% illegal foreign fishers (DIBP, 2015b)) – there was a remaining group who were detained for various other reasons, some of whom were also asylum seekers (e.g., some visa cancellations will also have been asylum seekers). Given the composition of the onshore and offshore immigration detention population, as well both types of community-based arrangements during this time, and for the sake of brevity, the overall population in this thesis will be referred to as the Australian asylum seeker population.

As at 31 July 2015, the largest numbers of asylum seekers in onshore detention and community detention were from Iran and Sri Lanka (DIBP, 2015b). Similarly, official

statistics from the Department of Home Affairs [DHA] (2015) indicate that as at 31 June 2015 the two main countries of origin for asylum seekers in community-based arrangements were Sri Lanka and Iran. Information relating to offshore processing (Refugee Council of Australia [RCOA], 2015) shows that the largest number of asylum seekers sent to Nauru and Manus Island during the study period were from Iran, the second largest group were stateless. There were also sizeable numbers of asylum seekers sent to Nauru and Manus Island at this time who were from Sri Lanka, Afghanistan, Pakistan and Iraq (RCOA, 2015).

Between 1 August 2014 and 31 July 2015, the 12-month period of relevance to this thesis, the average (or mean) estimated total number of adults across the entire Australia asylum seeker population was 28,981 (DIBP, 2015b). Males comprised 86.7% of the whole adult asylum seeker population, and females 13.3% of the population (DIBP, 2015b). Of these:

- 23,894 were in community-based arrangements
- 1,184 were in community detention
- 2,176 were detained in onshore immigration detention
- 722 were held in offshore detention on Nauru
- 1,005 were held in offshore detention on Manus Island

Table 1.1 below shows the average number of adults in the Australia asylum seeker population during the study period, including by processing arrangements and gender.

Table 1.1

Average number of adults in the Australian asylum seeker population between 1 August 2014 and 31 July 2015, by processing arrangements and gender

Processing arrangements	Males	Females	Total population
Community-based	21,136	2,758	23,894
Community detention	621	563	1,184
Onshore detention	1,815	361	2,176
Nauru	563	159	722
Manus Island*	1,005	-	1,005
Total	25,140	3,841	28,981

*Manus Island houses only male asylum seekers

Asylum seekers in community-based arrangements may live in a place of their own choosing on the Australian mainland, whereas asylum seekers held in community detention must live in a specified location (AHRC, 2016). Figure 1 provides an overview of the onshore immigration detention facilities that were operational during the study period. There are four main types of closed immigration detention facilities (AHRC, 2016) in the Australian onshore detention network:

- Immigration Detention Centres [IDCs]
- Immigration Transit Accommodation [ITA]
- Immigration Residential Housing [IRH]
- Alternative Places of Detention [APODs]

The location of these facilities can be found on the map in Figure 1.1 below.

Figure 1.1. Location and type of immigration detention facilities in the Australian onshore detention network.

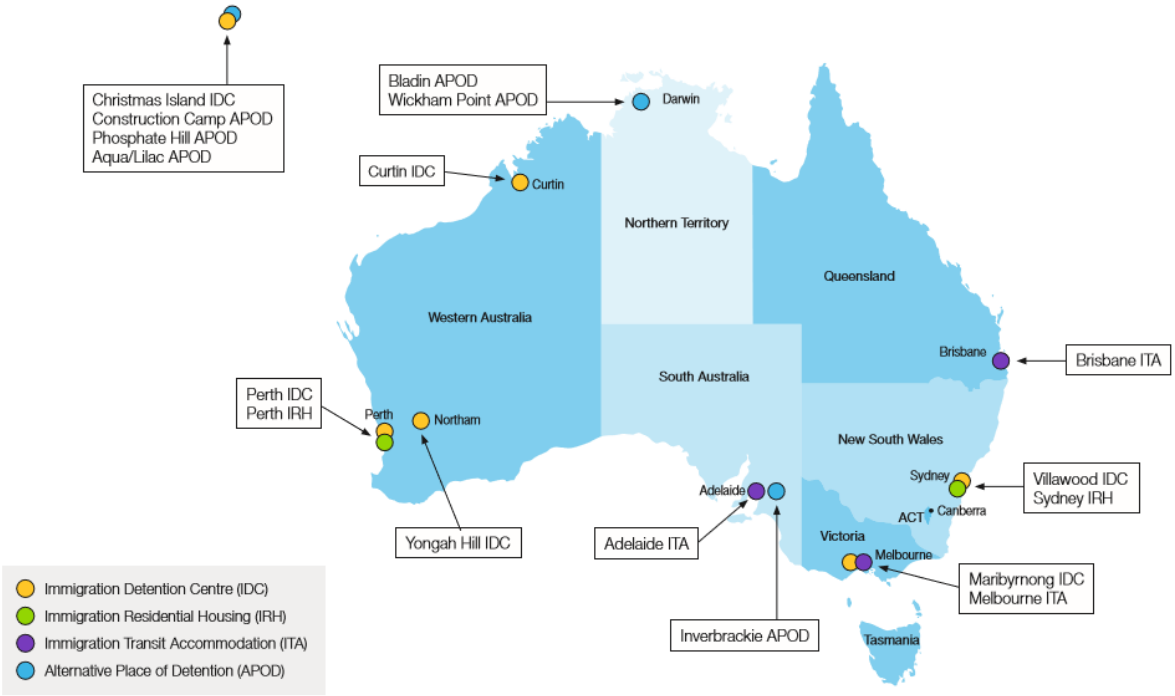

Figure 1.2 below provides an overview of the location of the Australian-run offshore immigration detention facilities on the Pacific island nation of Nauru, as well as on Manus Island, Papua New Guinea, including their distance from the Australian mainland, as well as information regarding the climate on both islands. Further details regarding each of the four types of onshore detention facilities, as well as the five main processing arrangements and their associated conditions, policies and processes are outlined in Chapter 2, as well as across the four main study chapters (6-9).

Figure 1.2. Location of the Australian-run offshore detention facilities in Nauru, and in Manus Island, PNG, their distance from the Australian mainland, and details regarding their climate.

1.3 Definitions

According to the United Nations High Commissioner for Refugees [UNHCR] (2010) a *refugee* is:

> a person who has 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 (their) nationality, and is unable, or owing to such fear, is unwilling, to avail (themselves) of the protection of that country (p.14).

The term *'asylum seeker'* is frequently conflated and/or confused with the term refugee. An asylum seeker is an individual who is seeking refugee 'protection, but whose claim for refugee status has not yet been determined' (Phillips, 2015, p.3).

Self-harm in this thesis is defined as all forms of intentional self-injury (or self-poisoning), irrespective of suicidal intent or motivation (Hawton, Harriss, Hall, Simkin, Bale, & Bond, 2003).

1.4 Thesis aims

This thesis examines the episode rates and key characteristics of self-harm among asylum seekers across the Australian asylum seeker population between 1 August 2014 and 31 July 2015. Specifically, across four distinct studies concerning asylum seekers in both detention and community-based settings, this thesis aims to:

1) Evaluate the quality of self-harm incident reporting across the entire Australian asylum seeker population;
2) Ascertain the incidence of self-harm among the Australian asylum seeker population;
3) Identify the characteristics associated with self-harm among the Australian asylum seeker population;
4) Determine whether episode rates and characteristics of self-harm vary according to processing arrangements (i.e., community-based arrangements, community detention, onshore detention, offshore detention [Nauru], and offshore detention [Manus Island]), and gender;
5) Determine whether episode rates and method(s) of self-harm in the Australian onshore detention network vary according to held detention type (i.e., whether asylum seekers are housed in Immigration Detention Centres [IDCs], Immigration Transit Accommodation [ITA], Immigration Residential Housing [IRH], or Alternative Places of Detention [APODs];
6) Examine how the distribution of self-harm, and methods used to self-harm across the Australian asylum seeker population, vary according to the 24-hour cycle, day of the week, and month of the year, including by processing arrangements.

The evidence produced as a consequence of this thesis fills both nationally and internationally recognised gaps in the literature, and may be used to inform the development of self-harm prevention strategies, as well as to improve governmental and clinical responses to self-harm among asylum seekers.

1.5 The candidate

I am a registered psychologist, with a Master's degree in Community Psychology, who has worked alongside people from asylum seeking and refugee backgrounds, in a range of roles and settings, for over 20 years. Most recently, I established a small private practice for people from asylum seeking, refugee and immigrant backgrounds in Melbourne's inner west. Since 2017, I have conducted independent mental health assessments and provided psychological reports for asylum seekers medically transferred to Australia from Nauru for the purposes of Refugee Status Determination. Prior to this, I was employed as a Counsellor/Advocate at the Victorian Foundation for Survivors of Torture (Foundation House) where I conducted psychological assessments, provided counselling and advocacy, and facilitated psychotherapeutic groups for community-based asylum seekers, as well as for refugees and humanitarian entrants, for a period of five years. I have also developed meaningful engagement programs for asylum seekers living in community detention.

As part of my Master's degree in Community Psychology at Victoria University, I completed a thesis examining self-harm among asylum seekers detained in the Australian onshore immigration detention network between 2009 and 2011 (publishing my findings in the *Journal of Forensic and Legal Medicine*). Prior to this, I earned a Graduate Diploma in Psychology, as well as an Honours degree in Psychology, at Flinders University, Adelaide, publishing my findings in the *European Journal of Social Psychology*. I have also completed a Bachelor of Arts (majoring in Sociology), as well as a Post-Graduate Diploma in Gender Studies/Social Sciences at La Trobe University, Melbourne, where I conducted a major

research project investigating psychosocial rehabilitation frameworks for survivors of torture. During this time, I also undertook further Certificate studies in Community Work, with a specialisation in cross-cultural communication. Following this, I worked in a number of not-for-profit organisations, as well as in community mental health and health promotion, largely with a focus on people from asylum seeking, refugee and immigrant backgrounds. This education, coupled with relevant work experience, has enabled me to work as a university lecturer and write curriculum, across the disciplines of psychology, sociology and criminology, for the past ten years. This includes researching, lecturing and writing curriculum on refugee and asylum seeker health, as well as the psychology of justice, for psychology, counselling, criminology, nursing and midwifery students.

This PhD study brings together, and builds upon, my main practice and research interests located at the intersection of health and human rights: self-harm among asylum seekers.

1.6 Thesis outline

This thesis consists of ten chapters. Chapter 2 provides a summary of the main pieces of national and international law governing Australian immigration policy since the introduction of mandatory immigration detention in 1992. Chapter 2 also includes a brief outline of the main types of onshore immigration detention and community-based arrangements, as well as the five main Australian asylum seeker populations during the study period, categorised according to processing arrangements**.** Chapter 3 provides a review of the mental health of asylum seekers, including regarding the impact of these immigration policies on asylum seekers, in both detained and community-based settings. Chapter 4 provides a broad overview of self-harm, including common risk factors, motivations, and associated costs. Chapter 4 also outlines what was known about self-harm in asylum seekers prior to this research, as well as the Australian government's self-harm monitoring and reporting processes. Chapter 4 concludes with a reiteration of the thesis aims, in light of the gaps identified in the literature

reviewed in both Chapters 3 and 4, and in the context of the policies governing Australia's treatment of asylum seekers, as outlined in Chapter 2.

Chapter 5 discusses the methodology and introduces the globally unique self-harm dataset developed for this thesis by the PhD candidate. Based on all self-harm incidents reported as occurring among asylum seekers over a 12-month period, obtained via *Freedom of Information* – the largest set of self-harm incident reports ever released from across the entire Australian asylum seeker population – I argue that the release of these data represents a unique opportunity to examine the episode rates and key characteristics of self-harm among the Australian asylum seeker population.

Chapter 6 (Study 1) presents an evaluation of the quality of self-harm incident reporting across the Australian asylum seeker population, according to the World Health Organization (WHO)'s (2016) self-harm reporting guidelines. Chapter 7 (Study 2) examines the episode rates and characteristics of self-harm among the Australian asylum seeker population, including by processing arrangements (i.e., community-based arrangements, community detention, onshore detention, offshore detention [Nauru], and offshore detention [Manus Island]), and gender. Chapter 8 (Study 3) investigates whether self-harm episode rates and method(s) of self-harm among asylum seekers in the Australian onshore detention network vary according to held detention type (i.e., Immigration Detention Centres [IDCs], Immigration Transit Accommodation [ITA], Immigration Residential Housing [IRH], or Alternative Places of Detention [APODs]). Chapter 9 (Study 4) examines how the distribution of self-harm episodes and method(s) used to self-harm vary according to the 24-hour cycle, day of the week, and month of the year, including by processing arrangements.

Chapter 10 provides a summary of the findings from the four studies (Chapters 6-9) and discusses the implications of these findings for broader self-harm prevention and management strategies among asylum seekers, in both detained and community-based

settings. The strengths and limitations of the four studies are also considered, as are the possible directions for future research.

Chapter 2: Australian immigration policies: A brief overview

For close to 30 years, successive Australian governments have implemented increasingly restrictive immigration policies. This chapter provides a condensed overview of the international and national legislation governing the treatment of asylum seekers during this time frame. It also contains a brief outline of the main types of onshore immigration detention and community-based arrangements used in Australia. Finally, it includes a summary of the five Australian asylum seeker populations during the current study period (1 August 2014 to 31 July 2015), as categorised according to processing arrangements.

2.1 The 1951 Refugee Convention

Before outlining a truncated summary of Australian policy governing the treatment of asylum seekers who have arrived by boat, it is necessary to make a comment on terminology. The terms 'asylum seeker' and 'refugee' have distinct meanings, however they are frequently confused and/or conflated. An asylum seeker is a person 'who is seeking refugee protection, but whose claim has not yet been determined' (Phillips, 2015, p.3). A refugee, on the other hand, is a person who has been recognised as a refugee under the *1951 Convention Relating to the Status of Refugees* (Refugee Convention) (United Nations High Commissioner for Refugees [UNHCR], 1951).

According to Article 1 of the Refugee Convention, a refugee is defined as:

> any 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/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that country
>
> (UNHCR, 2010, p. 14).

Australia, as a party to the 1951 Refugee Convention, and its 1967 Protocol, has made a commitment to assess claims for refugee protection according to these international human rights instruments (UNHCR, 2010). Australia therefore has an obligation not to return (under the principle of non-refoulement) individuals to countries where there is a reasonable or substantiated threat of persecution (UNHCR, 2010). Australia also has non-refoulement obligations based on other major international human rights instruments, such as the International Covenant on Civil and Political Rights (ICCPR), its Second Optional Protocol aiming at the abolition of the death penalty, and the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (CAT) (AHRC, 2017). In addition to this, the 1951 Convention clearly highlights that a refugee should not be penalised for any illegal entry into a country that is a signatory to the Convention (UNHCR, 2010). Accordingly, at an international level, Australia has made a number of commitments regarding the standard of treatment of refugees.

2.2 The Migration Act 1958

At a national level, the most significant piece of legislation regarding asylum seekers in Australia is the *Migration Act 1958* (Cth). The *Migration Act* forms the legislative basis for all types of migration and visa applications and 'regulates the coming into, and presence in, Australia of non-citizens' (1958, s. 4). Since its introduction in 1958, successive governments have made a number of amendments to the *Migration Act* to reflect their own agendas. Outlining all of these changes – many of which have had a considerable impact on those attempting to seek protection in Australia – is beyond the scope of this thesis. The remainder of this chapter will instead provide a summary of the main pieces of legislation that have impacted on the treatment of asylum seekers during the time frame in question.

2.3 Introduction of mandatory detention: 1992

The first, and possibly the most significant, amendment to the *Migration Act 1958* (Cth) (Migration Act) occurred in 1992, when the *Migration Reform Act 1992* (Cth) was introduced. These amendments to the Migration Act 'required the detention of certain 'designated persons', and prevented any judicial review of …(such) detention' (AHRC, 2013, p.4), although a 273-day limit on detention was initially imposed.

The policy of mandatory immigration detention was widened in 1994 to include 'all unlawful, non-citizens' (i.e., any non-citizen without 'valid documentation; such as a passport or visa') (Phillips & Spinks, 2013, p.6), and the nearly nine-month limit on detention was removed. Detention under such legislation continues until either a visa is granted or the person is removed from Australia (Phillips, 2015). Accordingly (until late 2011), all individuals who arrived by boat without valid documentation - referred to as irregular maritime arrivals (IMAs) - were detained and transferred to the Christmas Island detention facility (Phillips & Spinks, 2013). Other 'unlawful non-citizens' (for example visa over-stayers not considered to be a flight risk, and some air arrivals) were, however, able to acquire temporary legal status through the grant of a bridging visa, and consequently avoid being detained whilst their immigration status was being resolved (Phillips & Spinks, 2013).

2.4 Types of onshore immigration detention

Under Section 273 of the Migration Act, the Minister for Immigration has the authority to 'cause detention centres to be established and maintained', as well as to regulate their operations. There are four main types of held immigration detention in the Australian onshore detention network (which includes Christmas Island): Immigration Detention Centres [IDCs], Immigration Transit Accommodation [ITA], Immigration Residential Housing [IRH], and Alternative Places of Detention [APODs] (AHRC, 2016).

IDCs are closed detention facilities, with the highest security arrangements in the onshore detention network, such as razor wire fences, guards and other forms of prison-like surveillance (AHRC, 2016). IDCs are used to detain asylum seekers, those who overstay their visas, and individuals who may have had their visas cancelled or refused for character reasons (AHRC, 2016). ITA facilities are closed detention facilities that may have less stringent security features than IDCs. They were initially designed to house individuals who were being transferred to other detention facilities or who were being removed from Australia (AHRC, 2016). Immigration Residential Housing is classified as a secure form of detention, with lower security measures than IDCs. IRHs provides more flexible accommodation than IDCs or ITAs, including housing that can accommodate families, although they may also be used to house single male adults (AHRC, 2016). APODs are places designated by the Department of Immigration to be used for detaining asylum seekers assessed as posing little risk to the general community (AHRC, 2016). APODs are less secure than other types of held detention, and have a more domestic environment (generally for housing children and families) to provide individuals more privacy and the opportunity to do things like cook and eat together (AHRC, 2016). APODs may also include places in the wider community such as hotels, motels, and apartments, amongst other venues (RCOA, 2020a).

In 1997, the Australian government privatised the operation of immigration detention centres. Private companies contracted by the government to manage the day-to-day running of onshore detention facilities since this time have included Serco, International Health and Medical Services (IHMS), and G4S, amongst others (Commonwealth Immigration Ombudsman, 2013).

2.5 The ‘Pacific Solution’: 2001

By 2001, the policy of mandatory immigration detention had been in place for close to a decade. At this time, national and international attention regarding the physical and mental

health consequences of immigration detention had intensified (Joint Select Committee on Australia's Immigration Detention Network, 2012), and repeated protests by asylum seekers had occurred in several immigration detention facilities around Australia (Mares, 2002).

In August 2001, as a consequence of what became known as the 'Tampa crisis' (where the Norwegian merchant vessel *Tampa* intercepted a stricken Indonesian vessel and took on board 433 people seeking asylum (Kelly, 2002)), a range of further ad-hoc amendments to the Migration Act were made. These included excising islands (Christmas Island, Cocos Island, Ashmore Reef and Cartier Island) from Australia's migration zone so that asylum seekers could not claim asylum in Australia if they reached these territories (see *Migration Amendment (Excision from Migration Zone) Act 2001* (Cth)), empowering the navy to intercept boats heading towards Australian territories, and tow them away, and withdrawing asylum seekers' right to appeal their claims in the Federal Court (Phillips & Spinks, 2013).

Additional legislative measures were introduced in 2001, commonly referred to as the 'Pacific Solution' (AHRC, 2013). In accordance with this policy, asylum seekers who arrived by boat were sent to Nauru or Manus Island, Papua New Guinea, where they were detained in offshore processing centres whilst their claims for protection were being processed (Phillips & Spinks, 2013). Between 2001 and 2008, when this policy was subsequently dismantled, 1,637 people were detained on Nauru or Manus Island (Phillips & Spinks, 2013). Out of this group, 1,153 individuals were eventually sent to Australia or elsewhere for resettlement, including 705 to Australia (Phillips & Spinks, 2013).

2.6 Community detention and community-based arrangements: 2005-2011

In 2005, following the unlawful detention of permanent resident, Cornelia Rau (Palmer, 2005), and the unlawful deportation of Australia citizen, Vivian Alvarez/Solon (Commonwealth Immigration Ombudsman, 2013), the Australian government introduced a range of further legislative changes. Residence determination, commonly known as

community detention, was introduced via *The Migration Amendment (Detention Arrangements) Act 2005* (Cth), and *The Migration Act* was also amended so that children would only be held in immigration detention as a 'measure of last resort' (2005, s. 4AA). In addition to the above, an Immigration Ombudsman was appointed to regularly review the cases of all long-term detainees (Joint Select Committee on Australia's Immigration Detention Network, 2012).

Asylum seekers with a 'residence determination' or in community detention are able to live in the Australian community, however they must live at a fixed location, and follow particular reporting regulations (RCOA, 2020b). They are not permitted to work or study. Whilst community detention was first introduced in 2005, as noted above, the use of community detention was widened to include unaccompanied minors and families with particular vulnerabilities in October 2010 (Phillips & Spinks, 2013). In late 2011, the government also began greatly expanding the number of bridging visas granted to asylum seekers who had arrived by boat, and were held in detention, pending the finalisation of their protection claims (Joint Select Committee on Australia's Immigration Detention Network, 2012). That is to say, in 2011 a much larger proportion of asylum seekers who arrived by boat were no longer mandatorily detained until their protection claims were processed and an outcome was received: they were released on bridging visas and allowed to live freely in the Australia community, at a place of their own choosing, and without strict monitoring or supervision in place.

2.7 Resumption of offshore processing: 2012

In 2012, following an increase in the number of asylum seekers arriving by boat, as well as overcrowding in onshore detention, the Australia government resumed offshore processing for asylum seekers who arrived by boat on or after 13 August 2012 (AHRC, 2013; Karlsen & Phillips, 2014). This decision was based on the findings of the Expert Panel on Asylum

Seekers, which was commissioned by the government to provide advice regarding the management of asylum seekers, particularly those arriving by boat (Houston, Aristotle & L'Estrange, 2012). The Expert Panel's Final Report recommended that disincentives to irregular maritime journeys should be made so that there is 'no advantage' achieved by circumventing protection through regular means (Houston, Aristotle & L'Estrange, 2012). One of the short-term recommendations made by the Expert Panel was the resumption of offshore processing to discourage asylum seekers from attempting to travel to Australia by boat (Houston, Aristotle & L'Estrange, 2012). After establishing arrangements with Nauru and Manus Island, Australia recommenced the transfer of asylum seekers to Nauru in September, 2012 and to Manus Island in November of the same year (AHRC, 2013; Karlsen & Phillips, 2014).

2.8 Regional Resettlement Arrangement: 2013

In July 2013, the Australian government announced the signing of an agreement known as the Regional Resettlement Arrangement (RRA) with government of Papua New Guinea. According to the terms of the RRA, asylum seekers who arrive by boat after 19 July 2013 will be sent to Manus Island for processing and resettlement (Karlsen & Phillips, 2014). Under this policy, therefore, asylum seekers arriving by boat will no longer have the chance to be resettled in Australia. Individuals not found to be owed refugee protection will be returned to their country of origin (AHRC, 2013).

In August 2013, the subsequent signing of an (updated) Memorandum of Understanding (MoU) with the government of Nauru was announced by the Australian government (Karlsen & Phillips, 2014). This MoU (2012) outlined that the government of Nauru would allow individuals 'in need of international protection to settle in Nauru' (p.2), with arrangements and specific numbers subject to agreement between both governments.

Whilst the administration of the offshore processing centres in both Manus Island and Nauru has changed over time, the Australian government has outsourced the day-to-day running of these centres to private contractors such as Serco, Transfield, G4S, International Health and Medical Services, and Pacific International hospital, among others (Legal and Constitutional Affairs Reference Committee, 2017). Private contractors supplying garrison and welfare services have also changed over time, as well as across the two islands, and have included Save the Children, the Salvation Army, Canstruct, and Paladin, among others (ANAO, 2017).

2.9 Migration and Maritime Powers Legislation Amendment (Resolving the Asylum Legacy Caseload) Act: 2014

In December 2014, the Australian government introduced a suite of additional changes to the way it determines the asylum claims of people who arrived by boat between August 2012 and January 2014 - who had not yet been transferred offshore – known as the 'legacy caseload' (AHRC, 2019a). These included the re-introduction of three-year Temporary Protection Visas (TPVs), the introduction of five-year Safe Haven Enterprise Visas (SHEVs), as well as 'fast-track' processing, and limited legal assistance with restrictions or exclusions on the right to have an unsuccessful application for a protection visa reviewed (*Migration and Maritime Powers Legislation Amendment (Resolving the Asylum Legacy Caseload) Act 2014* (Cth)).

2.10 Summary

In summary, for close to thirty years, depending on mode and date of arrival, there has been a range of legislative arrangements governing Australia's treatment of asylum seekers who arrived by boat without valid documentation. Since the resumption of offshore processing in 2012, there have been five main Australian asylum seeker populations, which can be categorised according to processing arrangements. These are: (a) community-based asylum seekers; (b) those who are held in community detention; (c) those held in onshore immigration detention (which includes centres on the Australian mainland as well as on

Christmas Island); (d) those who are held in offshore immigration detention on Nauru and; (e) those held in offshore immigration detention on Manus Island. According to current legislation, no asylum seekers arriving by boat will be permanently settled in Australia (Karlsen & Phillips, 2014). Those already sent to Nauru or Manus Island will be resettled in these countries, or other third countries offering resettlement, if found to be refugees. Asylum seekers who arrived in Australia between August 2012 and January 2014 – who had not yet been subject to offshore processing – will only receive three- or five-year TPVs, if found to be genuine refugees (*Migration and Maritime Legislation and Amendment (Resolving the Asylum Legacy Caseload) Act 2014* (Cth)), and will not be able to apply for family reunion, amongst a range of other visa restrictions.

As will be explored in **Chapter 3 – The mental health of asylum seekers** – each of these processing arrangements, and their associated conditions, policies and practices, present a number of significant challenges for asylum seekers, which may detrimentally impact on their mental health.

Chapter 3: The mental health of asylum seekers

This chapter provides a review of the international and Australian literature concerning the mental health of asylum seekers. As will be outlined, whilst pre-arrival, peri-migration, *and* post-arrival stressors are all important predictors of poor mental health among asylum seekers, post-migration stressors, such as immigration detention, may be associated with adverse mental health outcomes over and above the effects of pre-arrival trauma and loss.

3.1 Prevalence of mental health issues

A large number of studies have reported on the prevalence rates of mental health disorders in asylum seeker and refugee populations (Fazel, Wheeler, & Danesh, 2005; Steel et al., 2009; Turrini et al., 2017). According to an umbrella review of 27 systematic reviews by Turrini and colleagues (2017), the most common mental health disorders experienced by asylum seekers and refugees are PTSD, depression, and anxiety disorders. Whilst rates of mental illness have been found to vary considerably across studies, this is likely due to the fact that asylum seeker and refugee populations are diverse, and exposure to trauma and other stressors vary, as do protective factors. What has been consistently observed across several decades, and a number of different populations, is that rates of mental illness are elevated in asylum seekers and refugees compared to the general population (see Fazel et al., 2005; Steel et al., 2009; Turrini et al., 2017). A meta-analysis by Steel and colleagues (2009), for example, of 181 studies (comprising 81,866 refugees or other conflicted affected persons) reported PTSD and depression prevalence rates of 30.6% and 30.8%, respectively. By contrast, prevalence rates in the general Australian community for PTSD are 4.4% (12 month) and 7.2% (lifetime) (McEvoy, Grove, & Slade, 2011), and for depression, 6.2% (12 month), and 15% (lifetime) (Beyond Blue, 2020). When taken together, these findings demonstrate that rates of mental illness among asylum seekers, refugees and other conflict

affected populations, are often high, and across studies prevalence rates are consistently higher than in the general community.

3.2 Factors associated with psychological distress

As noted above, asylum seeker populations are diverse, and exposure to stressors that impact mental health may vary. In attempting to understand mental health risk among asylum seekers, then, it is important to consider the range of factors that may detrimentally impact on mental health. Whilst a great deal of research has focused on pre-arrival trauma as the key predictor of poor mental health among asylum seekers and refugees, research has also observed that rates of mental illness may be predicted by pre-, peri, *and* post-arrival stressors (Porter & Haslam, 2005; Priebe, Giacco, & El-Nagib, 2016). When taken together, these stressors include a variety of individual, family, socioeconomic, structural, political, procedural and environmental factors. Table 3.1 outlines the pre- and post-arrival stressors commonly associated with poor mental health, as well as those that may be experienced during flight, as identified in Australian and international research.

Table 3.1

Pre-arrival, peri-migration, and post-arrival stressors commonly associated with poor mental health in asylum seekers and refugees

Pre-arrival stressors	**Peri-migration stressors**	**Post-arrival stressors**
Being tortured, including the torture of family members or close others	Dangerous travel, including via land or sea routes	Insecure visa status
Witnessing or experiencing violence (physical or sexual) or conflict	Exposure to violent events or (physical or sexual) assaults	Housing and food insecurity
Acts of persecution	Human trafficking, including of family members	Lack of adequate legal support
Imprisonment	Separation from family members or close others	Uncertainty regarding asylum claim process
Exposure to economic hardship and social deprivation	Extreme hardship	Limited or no work rights
History of mental health issues	Insecurity and protracted time spent in transit countries	No access to study rights
		No or variable access to health care
		Separation from immediate or extended family members, including children
		No access to family reunification
		Visa processing freeze
		Discrimination
		Prolonged immigration detention

3.3 Pre-arrival trauma and loss

In country of origin, pre-arrival experiences that may be psychologically harmful to asylum seekers and refugees include persecution, war or armed conflict, economic hardship, and social deprivation. Experiences of persecution for political, ethnic, religious or other reasons include: being tortured, including the torture of family members or close others (Hynie, 2018; Iversen & Morken, 2003; Steel et al., 2009; Nickerson, Schick, Schnyder, Bryant, & Morina,

2017; Opaas & Varvin, 2015); witnessing or experiencing physical or sexual violence or conflict, including violence that inflicts injury or death on family members, friends and communities (Chen, Hall, Ling, & Renzaho, 2017; Lindencrona, Ekblad, & Hauff, 2008; Priebe et al., 2013; Schweitzer et al., 2018); denial of access to education, employment, health, and the right to practice one's faith, economic hardship, and social deprivation (Priebe et al., 2013) (see Table 3.1). Research has also found that the risk of developing a mental illness increases with exposure to multiple potentially traumatic pre-arrival experiences and/or if post-arrival stress is experienced following exposure to pre-migration trauma (Chen et al., 2017; Kartal, Alkemade, Eisenbruch, & Kissane, 2018; Nickerson et al., 2017; Schweitzer et al., 2018).

3.4 Peri-migration stressors

Common peri-migration stressors experienced during flight, and in countries of temporary sanctuary that may be psychologically harmful to asylum seekers and refugees, as identified in the literature, include: dangerous travel, including via land or sea routes (Bell & Zech, 2009; Ben Farhat et al., 2018; Poole, Hedt-Gauthier, Liao, Raymond, & Barnighausen, 2018); exposure to violent events or assault (Ben Farhat et al., 2018; Gebreyesus, et al., 2019); human trafficking (RCOA, 2017; WHO, 2018), including of family members, separation from family members or close others (Miller, Hess, Bybee, & Gookind, 2018); and extreme hardship, insecurity, and protracted time spent in transit countries (Bjertruup et al., 2018) (see Table 3.1).

3.5 Post-arrival stressors

Post-arrival stressors in the Australian and international context, as reported across a number of different studies, have been found to include: insecure visa status (Li, Liddell, & Nickerson, 2016; Newnham, Pearman, Olinga-Shannon, & Nickerson, 2019; Steel et al., 2006; Steel et al, 2011); housing and food insecurity (Porter & Haslam, 2005); lack of

adequate legal support (Kenny, Procter, & Grech, 2016); uncertainty regarding asylum claim process (Kenny & Procter, 2015); limited or no work rights, no access to education, no or variable access to health care (Fleay, Hartley, & Kenny, 2013; Kenny et al., 2016; RCOA, 2018); separation from immediate and/or extended family members, including children (Medicin sans Frontiers, 2018; Miller et al., 2018; Priebe et al., 2016); no access to family reunification (RCOA, 2018); discrimination, and immigration detention for asylum seekers (von Werthern et al., 2018) - to be considered in further detail in **Section 3.7** – **Immigration detention**, below.

Post-arrival stressors, such as those outlined above (and summarised in Table 3.1) are important predictors of poor mental health in asylum seekers and refugees, and in some cases, may be more so than pre-arrival experiences. Indeed, research (see Chu, Keller, & Rasmussen, 2013; Porter & Haslam, 2005; Schweitzer et al., 2011; Tempany, 2009) has observed that post-migration stressors, such as housing and food insecurity, lack of employment, and separation from family, may more strongly predict psychological distress than pre-arrival or peri-migration stressors. Furthermore, research also highlights that mental health may deteriorate as the duration of exposure to post-arrival stressors increases (Hynie, 2018; Mulugeta et al., 2019), with poorer mental health outcomes observed at 5 years post-arrival than in the early settlement period (Bogic, Njoku, & Priebe, 2015). Such findings point to the importance of both recognising and addressing key post-migration stressors and conditions in order to improve the mental health of asylum seekers, as will be further outlined in **Section 3.6 – The impact of policy**, below.

Summary of pre-arrival, peri-migration and post-migration stressors

There is a range of pre-arrival, peri-migration, post-arrival stressors, as highlighted in the literature, observed to impact detrimentally on the mental health of asylum seekers. Such stressors include a variety of individual, family, socioeconomic, structural, political,

procedural and environmental factors. Whilst pre-arrival stressors have been found to be associated with a number of significant, negative consequences for the mental health of asylum seekers, a number of studies have demonstrated that post-migration stressors are significantly associated with deleterious mental health consequences over and above the effects of pre-arrival trauma and loss.

3.6 Impact of policy

In the Australian context, many of the post-arrival stressors found to have adverse mental health outcomes for asylum seekers can be directly linked to government policy. As an example, the re-introduction of three-year Temporary Protection Visas (TPVs) and the introduction of five-year Safe Haven Enterprise Visas (SHEVs) in 2014 (*Migration and Maritime Legislation and Amendment (Resolving the Asylum Legacy Caseload) Act 2014* (Cth)) cause asylum seekers to experience ongoing visa and residency insecurity, which in turn is associated with poor mental health (Kaldor Centre, 2019; Kenny et al., 2016; RCOA, 2018). Indeed, due to being placed in a state of legal uncertainty, asylum seekers with TPVs may experience ongoing fear and uncertainty about being sent back to a country where they fear persecution (Steel et al., 2006). Furthermore, TPV holders are prevented from applying to bring family members to Australia by law, an established source of considerable psychological distress (RCOA, 2018).

Research by Momartin et al. (2006), conducted when TPVs were first introduced in Australia (before being repealed in 2008), clearly demonstrated the negative effects of this immigration policy on the mental health of asylum seekers. In a study designed to determine the impact of the provision of temporary visa status, compared with permanent visa status, Momartin and colleagues (2006) found that TPV holders experience higher rates of psychiatric disturbance on a range of measures, compared with Permanent Protection Visa (PPV) holders. Furthermore, in this study, TPV status was found to be the strongest predictor of anxiety,

depression, and PTSD, demonstrating how critical stability and certainty is for mental health. Additional evidence of the deleterious consequences of this government policy on mental health was detailed in a two-year longitudinal study of asylum seekers released from detention with TPVs, and those granted PPVs before entering Australia, conducted by Steel and colleagues (2011). Steel et al. (2011) observed that TPV holders had higher scores on measures of PTSD, anxiety and depression than PPVs, and in contrast with PPV holders, scores remained high for TPVs over the two-year study period. TPV holders also reported lower social integration and English language skills than PPV holders. When taken together, these findings clearly highlight the detrimental impact of restrictive immigration policies on the mental health of asylum seekers in the post-migration period.

A further example of a post-arrival stressor for asylum seekers which can be directly linked to government policy is the lack of work rights for the several thousand asylum seekers living in the Australian community on bridging visas (Karlsen & Phillips, 2014). Asylum seekers released into the community during 2014 were not granted work rights until December 2014 (Asylum Insight, 2018), which had a range of negative outcomes, including food and housing insecurity, as well as adverse outcomes in relation to their physical and mental health. As access to universal health care for many community-based asylum seekers is also limited, or in many cases frequently interrupted due to changes in visa status or the need to renew bridging visas, such policies are observed to have significant, detrimental effects on the mental and physical health of asylum seekers (RCOA, 2018). The policy of no or few work rights, as well as no or limited access to universal health care for community-based asylum seekers, continues up until the present day, with a number of negative consequences for asylum seekers (RCOA, 2018).

3.7 Immigration detention

The adverse mental health consequences of Australia's policy of mandatory immigration detention for asylum seekers who arrive by boat without valid documentation have been unequivocally established (Commonwealth Immigration Ombudsman, 2013; Green & Eager, 2010; Young & Gordon, 2016). Indeed, a large body of research, as well as a number of government and other inquiries, has provided evidence of the detrimental psychological effects of Australia's policy of onshore immigration detention, as well as offshore processing on the Pacific island nation of Nauru, as well as Manus Island (AHRC, 2014; Coffey, Kaplan, Sampson, & Tucci, 2010; Commonwealth Immigration Ombudsman, 2013; Green & Eager, 2010; Mares & Jureidini, 2004; Medecin sans Frontieres [MSF], 2018; Moss, 2015; Legal and Constitutional Affairs Reference Committee, 2017; Steel et al., 2006). Before canvassing some of the conditions and practices in onshore and offshore immigration known to adversely impact on mental health, I will first outline what is known in a broader sense about the negative psychological implications of immigration detention on the mental health of asylum seekers.

Being detained in immigration detention is a stressful post-migration experience that involves being deprived of liberty (Robjant, Hassan, & Katona, 2009). Those held in detention may fear being forcibly removed to their country of origin, where they may have experienced persecution. Detention also increases the potential risk of violence and exploitation, as well as social isolation, factors known to impact detrimentally on mental health (Priebe et al., 2016). A 2018 review of the impact of immigration detention found that high rates of anxiety, depression, PTSD, as well as poor quality of life were consistently reported across several Australian and international studies involving detained asylum seekers (von Werthern et al., 2018). Although these mental health concerns may arise from pre-migration trauma and loss, or adverse experiences occurring during flight, such vulnerabilities do not wholly account for

the rates of mental illness observed. Indeed, several studies comparing detained and non-detained asylum seekers have reported elevated levels of mental health symptoms among detained asylum seekers, meaning that detention itself is an independent contributor to poor psychological functioning in asylum seekers (Cleveland & Rousseau, 2013; Ichikawa, Nakahara, & Wakai, 2006; Momartin et al., 2006; Steel et al., 2006; Steel et al., 2011).

Being separated from family members has also been found to increase symptoms of depression and PTSD among detained asylum seekers (Steel et al., 2006). According to the Australian Human Rights Commission [AHRC] (National Inquiry into Children in Immigration Detention) in 2014, 85% of parents and children detained in the Australian onshore detention population reported that their mental health had declined since being held in detention, which included the psychological effects of being separated from immediate and extended family members. In addition, mental health has been observed to deteriorate with time spent in detention, with detention duration positively associated with symptom severity (Steel et al., 2006; Young & Gordon, 2016), and the chance of developing a new mental illness found to significantly increase from three months (Green & Eager, 2010). Furthermore, research indicates that the negative effects of immigration detention on mental health may be enduring, with asylum seekers found to experience poor mental health, including depression, concentration and memory disturbances, as well as pervasive anxiety, for several years following release from detention (Coffey et al., 2010). When taken together, the extant literature unequivocally demonstrates that immigration detention is one of the most significant post-migration stressors, and that it has detrimental and ongoing implications for the mental health of asylum seekers.

Factors common to onshore and offshore immigration detention

Both government bodies and non-government organisations and investigators, as well as academics, have reported on the conditions, policies, and practices in onshore immigration detention, as well as the Australian-run offshore processing centres on Nauru and Manus Island observed to impact on mental health (AHRC, 2014; AHRC, 2019b; Commonwealth Immigration Ombudsman, 2013; Joint Select Committee on Australia's Immigration Detention Network, 2012; Steel et al., 2004). Several of the factors found to affect mental health, as identified in the literature, are common to onshore and offshore immigration detention and are summarised in Table 3.2.

Table 3.2

Factors common to onshore and offshore detention found to affect the mental health of asylum seekers

Factors of concern
• protracted detention • physical and material conditions of detention • lack of adequate physical and mental health support • separation from immediate and extended family members, including children • violence and abuse from other detainees, staff and contractors • lack of meaningful activities • lack of adequate legal support • protracted visa processing times

3.8 Factors specific to offshore detention

Other factors observed to adversely affect the mental health of detained asylum seekers are, however, specific to either the offshore processing centres in Nauru and/or Manus Island, or the Australian onshore detention network. For asylum seekers in offshore immigration detention – on both Nauru and Manus Island – such factors include the remote location of the islands from the Australian mainland, very poor or limited mental and physical health care, lack of access to medical and other specialists, security and personal safety concerns, with a number of attacks on asylum seekers by contractors and locals reported both during 2014-15, and following the study period (AHRC, 2017; Legal and Constitutional Affairs Reference Committee, 2017). Factors also include the lack of adequate settlement services, lack of third country resettlement options, and chronic physical health concerns due to the offshore detention environments (AHRC, 2017; Legal and Constitutional Affairs Reference Committee, 2017). Such physical health conditions include, but are not limited to, respiratory conditions, particularly on Nauru (due to dust and cadmium levels from decades of phosphate mining), kidney disease, and a high prevalence of kidney stones due to the poor and/or limited water supply, as well as those related to the hot and humid climate, such as dengue fever, zika virus and chikungunya, and serious skin infections (IHMS, 2015). Medical trends have also emerged relating to a diet lacking in fresh produce (Legal and Constitutional Affairs Reference Committee, 2017).

3.9 Factors specific to Nauru

For asylum seekers detained on Nauru, human rights, media and other reports have highlighted that sexual assaults and violence against women and children are commonplace, contributing to significant psychological distress (AHRC, 2014; Medecin sans Frontieres, 2018; Moss, 2015; RCOA & Asylum Seeker Resource Centre, 2018). Indeed, during the study period, a number of allegations regarding sexual assaults involving women and

children were made, prompting a government inquiry, which later became the Moss (2015) review. As outlined in both the final Moss (2015) report, as well as the AHRC's (2014) 'The Forgotten Children' report, such assaults contributed to high levels of ongoing psychological distress and suffering among a number of women and children detained on Nauru.

In addition to the aforementioned allegations of sexual assault and violence, reports indicate that there was considerable uncertainty amongst asylum seekers in Nauru regarding the possibility of being able to apply for an Australian visa. This uncertainty was due to a number of policy changes being enacted at this time, resulting in some asylum seekers being returned to the Australian mainland for processing (Karlsen, 2016). Any remaining hope regarding applying for an Australian visa for asylum seekers detained on Nauru during the study period was closed in a video announcement made by the Minister for Immigration and played for those held on Nauru in late September 2014 (New Matilda, 2014). The following day the Minister announced that asylum seekers may be resettled in Cambodia (Department of Foreign Affairs and Trade, 2014), which reportedly contributed to further uncertainty and distress among asylum seekers detained on Nauru (Dingle, 2014).

3.10 Factors specific to Manus Island

For asylum seekers detained on Manus Island, factors observed to contribute to poor mental and physical health, in addition to those common to both offshore processing centres, include considerable security and personal safety concerns. Indeed, human rights, media and other reports have highlighted that threats to asylum seekers' safety, including acts of violence and intimidation from locals and security personnel have occurred frequently on Manus Island (Amnesty International, 2014; Amnesty International & RCOA, 2018; Davidson & Doherty, 2015), causing ongoing fear and psychological distress. In addition to this, during the study period, the first refugee status determinations since the recommencement of offshore processing were handed down, with those found to be refugees informed that they were to be

transferred to insecure accommodation in another location in PNG (Ministry of Foreign Affairs and Immigration Officer of the Minister (PNG), 2014), without adequate settlement services and means to live safely.

Sexual violence against male asylum seekers was also reported during this period (Amnesty International, 2014). Such personal safety and security concerns have been observed to contribute to physical and mental ill health among asylum seekers detained on Manus, as well unrest and conflict reported both at this time, and in subsequent periods (Amnesty International, 2014; Amnesty International & RCOA, 2018). Furthermore, Manus Island did not have a non-government organisation [NGO] operating on the island and providing welfare and garrison services – due to the Australian government's outsourcing of these responsibilities to private contractors – for the whole of the study period (ANAO, 2017). Independent reports confirm that workers on Manus were difficult to source and retain during the time frame in question (ANAO, 2017). Such staffing issues would almost certainly have impacted on the perception of the personal safety and security of those detained on Manus Island during this time frame, contributing to both mental and physical ill health.

3.11 Factors specific to onshore detention

For asylum seekers held in onshore immigration detention, factors observed to impact on mental health, in addition to those shared across both onshore and offshore detention, include frequent transfers across the immigration detention network, usually with little or no notice (AHRC, 2014; Hedrick, 2017). These transfers, which generally occur very early in the morning, often result in the separation of family members, including children, causing considerable psychological distress (AHRC, 2014; Hedrick, 2017). Indeed, expert testimonies contained in 'The Forgotten Children' report (AHRC, 2014) conducted during the study period, highlight numerous examples of parents and children being separated across the Australian detention network as a consequence of such transfers. In addition to transfers

causing distress for families, parents, and children, they have also been observed to disrupt asylum seekers' support networks, including relationships with legal representatives, medical specialists, torture and trauma counsellors, and extended family or friends who may have regularly visited or otherwise provided support (AHRC, 2019b; Peterie, 2020). In this way, not only do transfers across the detention network further socially isolate asylum seekers, but they may also impact on their claim preparation, and disrupt the physical and psychological treatment and support they may have been receiving to that point.

Types of held detention

Other factors known to adversely affect the mental health of asylum seekers in the onshore detention network include the types of detention in which they are held. As noted in **Chapter 2, section 2.4 – Types of onshore immigration detention**, as well as in the Introduction, asylum seekers in the onshore detention network may be held in a number of different types of 'closed' immigration detention, including Immigration Detention Centres [IDCs], Immigration Transit Accommodation [ITA], Immigration Residential Housing [IRH], and Alternative Places of Detention [APODs] (AHRC, 2016). The frequent transfers across the detention network highlighted above mean that many asylum seekers have been detained in a number of these different types of detention. The high security features found in IDCs, such as razor-wire fences, guards, and other prison-like surveillance measures, have been observed to cause distress and fear among detained asylum seekers – particularly as immigration detention is framed as being 'administrative and not punitive' (Australian Border Force, 2020, p.1).

The lower security detention arrangements, however, such as ITAs and APODS, have also been observed to distress asylum seekers held in these arrangements. Indeed, research (Essex & Govintharajah, 2016) and independent reports (AHRC, 2014) concerning these types of detention arrangements deemed to be 'lower security' – often used for families with children,

and other vulnerable adults – have observed that such environments often strip parents of their autonomy and control over every day parenting tasks, such as meal, play, and sleep times, as well as easy access to food and nappies, contributing to significant feelings of parental disempowerment. As also highlighted in the literature, such environments are often 'lower security' in name only, and often retain other high security practices such as the handcuffing of asylum seekers taken to medical or external counselling appointments, which is experienced as both distressing and humiliating for asylum seekers (AHRC, 2019c).

3.12 Summary

Across a number of studies, and over several decades, research has demonstrated that asylum seekers experience rates of depression, anxiety and PTSD that are many times higher than in the general community. Whilst pre-arrival, peri-migration, and post-migration stressors have all been observed to contribute to poor mental health outcomes for asylum seekers, post-migration stressors may be associated with adverse mental health outcomes over and above the effects of pre-arrival trauma and loss. In Australia, many of these post-migration stressors may be directly linked to government policy, such as mandatory, indefinite immigration detention. There are several conditions and practices shared across both onshore and offshore immigration detention, as well those specific to either Nauru, Manus Island, or onshore detention in Australia, that have been observed to be psychologically harmful. Although concerns regarding these harmful conditions and practices have been frequently and persistently raised over a number of years, Australia continues to detain asylum seekers in both onshore and offshore immigration detention.

Chapter 4: Self-harm

Research has demonstrated that immigration detention may cause psychological harm to asylum seekers. However, research regarding self-harm among asylum seekers has been very limited (Hedrick, 2017). This chapter outlines the definition of self-harm used throughout this thesis, reviews common self-harming behaviours, the main risk factors, common motivations and functions, as well as the costs associated with self-harm. It also summarises the extant research regarding self-harm across the Australian asylum seeker population, before highlighting the Australian government's self-harm monitoring and reporting processes, and the consequences of these practices for the health of this vulnerable population. The chapter concludes with a reiteration of the thesis' aims, in light of the gaps in the literature identified in the review.

4.1 Definition

Whilst there has been much academic interest in self-harm for several decades, there has been no universal agreement as to the definition of self-harm. In addition to 'self-harm', the research literature is full of references to terms such as 'self-injury', 'self-poisoning', 'intentional self-harm', 'para-suicide', 'non-suicidal self-injury' (NSSI), and 'self-injurious behaviour', amongst others (Carter, Page, Large, et al., 2016; Schmidtke, Bille-Brahe, DeLeo, et al., 1996; Skegg, 2005; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). This variation in terminology has arguably held back research in this field. Sometimes these terms are taken to be synonyms, whilst at other times they are referred to as distinct behaviours. Perhaps it is due to such ambiguity, that self-harm has historically been used as an umbrella term which involves all forms of intentional self-injury (or self-poisoning), irrespective of suicidal intent or motivation (Hawton et al., 2003). Throughout this thesis, the term self-harm will be used to refer to all forms of behaviour covered in this definition.

4.2 Self-harm behaviours

Self-harm covers a wide range of behaviours. These behaviours are often separated into two separate groups: self-injury and self-poisoning (National Collaborating Centre for Mental Health, 2004). Self-injury may include behaviours such as cutting, bruising or biting the skin, burning the skin, picking or scratching, self-battery – which often includes head banging – as well as swallowing foreign objects (Nock, 2010). Self-poisoning includes intentionally ingesting and overdosing on illicit substances, medication, or chemicals (household or other) (Hawton et al., 2006). Self-poisoning and cutting are generally the most commonly reported forms of self-harm (Carter et al., 2016), as well as those that account for the highest rates of hospital presentations in the general community (Pointer, 2015). In 2012-13, for example, intentional self-poisoning accounted for 83% of all hospital-treated cases of self-harm in Australia, whilst self-harm by cutting accounted for 12% of all hospitalised cases during the reporting period (Pointer, 2015).

Self-harm also includes other more violent behaviours, such as attempted hanging, although this type of self-harm is less common, accounting for 2% of all hospitalised cases of self-harm in Australia in 2012-13 (Hedrick, 2017; Pointer, 2015). Research has suggested that men are typically more likely to select more violent and potentially lethal methods of self-harm than women (Canner, Guiliano, Selvarajah, Hammond & Schneider, 2016). Indeed, substantially more males than females (456 and 203 cases, respectively) were involved in hospital-treated episodes of self-harm involving attempted hanging in Australia in 2012-13 (Pointer, 2015). There is also evidence, however, that gendered differences in self-harm methods may vary according to country of origin (Goosen et al., 2011; Sundvall, Tidemalm, Titelman, Runeson, & Bäärnhielm, 2015). What has been clearly established is that self-harm is one of the strongest predictors of suicide (Hawton et al., 2015; Owens, Horrocks, & House, 2002; Skegg, 2005), and a leading cause of injury and premature death (Bergen et al., 2012;

Carroll, Metcalfe, & Gunnell, 2014) around the world. Whilst many countries, including Australia, have developed national self-harm prevention strategies in order to reduce self-harm (Suicide Prevention Australia, 2019), such strategies do not extend to the Australian asylum seeker population, in either community-based, onshore or offshore settings.

4.3 Risk factors

There are a number of risk and protective factors for self-harm, as identified in the literature (Skegg, 2005), clinical guidelines (Carter et al., 2016; National Collaborating Centre for Mental Health, 2004), and in global self-harm and suicide prevention strategies (WHO, 2014). These include personal, social, and contextual factors, as summarised in Table 4.1 below. Some of the most common risk factors for self-harm include: younger age, adverse life experiences, socioeconomic disadvantage, mental health disorders, and social isolation. Asylum seekers have most of these risk factors (Cohen, 2008; Hedrick, 2017), as the literature examined in Chapter 3 has already illuminated.

Table 4.1

Risk factors for self-harm (adapted from Skegg, 2005)

Risk factors for self-harm
Demographic profile
Younger age
Female gender
Socioeconomic disadvantage
Mental health disorders
Social isolation
Lower level of education
Social and family environment
Adverse childhood environment and experiences
Interpersonal difficulties in adolescence
Situational factors
Adverse life events
Awareness of self-harm of others
Media influence
Intoxication
Mental health disorders
Depression
Anxiety
Personality disorder
Previous contact with mental health services, including psychiatric admission
Physical illness
Poor general health

Being incarcerated is known to further increase self-harm risk, with rates of self-harm found to be higher in detained populations than in community populations (Franke, Vogel, Eher, & Dudek, 2019; Hawton et al., 2013; Moller, Stover, Jurgens, Gatherer & Nikogosian, 2007). Research conducted among prisoners detained in the UK and Wales between 2004 and 2009,

for example, estimated the annual total (male and female) prevalence of self-harm as 6-7% (Hawton et al., 2013). By comparison, 0.6% of the general UK population reported self-harming in the preceding year (Hawton et al., 2013). The risk of self-harm in detention has been found to be further elevated under certain detention circumstances or settings, such as when duration of detention is indeterminate (i.e., when given a life sentence) or when length or duration is uncertain (i.e., when held in remand centre/transit accommodation) (Hawton et al., 2013). Research has also observed that the higher risk of self-harm for detained individuals persists following their release from detention (Borschmann et al., 2017).

Evidence has also found that whilst women are generally under-represented in detained populations, they are often over-represented in self-harm incidents in detention settings (Australian Institute of Health and Welfare [AIHW], 2013; Hawton et al., 2013). Whilst the Australian prison population was comprised of 93% males in 2012, for example, almost twice the proportion of females than males (28% to 15%) reported having self-harmed (AIHW, 2013). In addition, individuals in detained populations have been observed to improvise in their use of self-harm methods, often when more traditional means are not accessible to them, and that these means often relate directly to the environment or setting in which they are housed (D'arcy, 2017; Tartaro & Lester, 2010). Further research also indicates that the frequency of self-harm episodes may vary throughout the 24-hour cycle, day of the week, and possibly month of the year (Bergen & Hawton, 2007; Blenkiron, House, & Milnes, 2000; Irish Prison Service, 2018; National Self-harm Registry Ireland, 2017). Recent research among incarcerated adults (Irish Prison Service, 2018), for example, found that the number of self-harm episodes gradually increased throughout the day, with some variation in distribution also found for month of occurrence. Possible explanations for these epidemiological findings include links to the environment or detention practices and procedures (Franke et al., 2019).

4.4 Functions

Self-harm is a behaviour, generally understood as a coping or survival mechanism, (Klonsky, 2007), and as a way of regulating or reducing overwhelming psychological distress (Hooley, 2008; Spandler & Warner, 2007). There are several functions for self-harm reported in the literature, and these have been linked to the individual, as well as to the external environment or events, or indeed to both the individual and the environment (Klonsky, 2007; Skegg, 2005; WHO & International Association for Suicide Prevention, 2007; WHO, 2014). The most common motivations for acts of self-harm by both males and females identified in a study by Martin and colleagues (2010) were to manage emotions (57%), followed by self-punishment (24%). Other frequent reasons identified by Klonsky (2007) include communicating with or influencing others, sensation-seeking and establishing a sense of personal control. Additional reported motivations for self-harm include: to provide distraction from painful feelings, to relieve tension, as well as to block distressing emotions (Peterson, Freedenthal, Shelden, & Andersen, 2008; Skegg, 2005). In short, self-harm is motivated by a range of different factors, with the regulation of emotions being one of the more commonly cited motivations.

4.5 Costs associated with self-harm

There are a number of significant costs associated with self-harm. These include costs to the individual, at a physical, psychological, social, and economic level, as well as to families, the broader community, and at a public health level (National Collaborating Centre for Mental Health, 2011). Research has also shown that the personal and public health burdens associated with self-harm increase with repetition (Sinclair et al., 2011). These include costs associated with medical care, hospitalisation, and subsequent or ongoing treatment for physical and psychological injuries (Sinclair et al., 2011). Other costs include those related to time off or incapacity to work, study, or participate in family duties or community activities (National Collaborating Centre for Mental Health, 2004). Importantly, such costs also include

death, with further impacts for families and communities, as self-harm is strongly associated with suicide, as previously outlined (Hawton et al., 2015).

Summary of self-harm

There are a number of established risk factors for self-harm, with asylum seekers observed to possess many of these. Being incarcerated is known to further increase self-harm risk, with detention type or setting found to elevate this risk yet again. Females are particularly at risk. Self-harm has also been found to vary according to the time of day and month of the year, highlighting potential associations with the environment or external events. Self-harm most commonly functions as a means of coping with or regulating overwhelming psychological distress, and the costs at a personal, social and public health level are high. Given asylum seekers' elevated risk of self-harm, Australia's policy of mandatory immigration detention, the various settings in which asylum seekers are detained, and the evidence of the significant costs associated with self-harm, research regarding self-harm in asylum seekers is a matter of urgency.

4.6 Self-harm in asylum seekers

Although few epidemiological studies of self-harm across the entire onshore Australian asylum seeker population have been conducted, studies looking at sub-sections of the population have reported a high prevalence of self-harm in adult asylum seekers. A study by Mares and Jureidini (2004), for example, involving 16 adults held in Australian immigration detention, found that 31% reported engaging in self-harm whilst detained. (Whilst this study found that 40% of (20) children also assessed had engaged in self-harm, the focus of this review is adults only). Similarly, a study by Steel and colleagues (2004) involving 10 detained families (14 adults and 20 children), highlighted that 36% of adults retrospectively reported having self-harmed whilst in detention. Furthermore, a 2011 study investigating the use of Emergency Departments (ED) by immigration detainees in Darwin, Northern

Territory, found that of 624 ED attendances by adults over a 12-month period, 129 (20%) presentations were for self-harm (Deans et al., 2013). In addition, a review of the Commonwealth Immigration Ombudsman's six-monthly reports – of those held in Australian immigration detention for two or more years – by Bull, Schindeler, Berkman, and Ransley (2012) found that approximately 25% of a sample of 228 long-term detainees reported having self-harmed in detention. A study replicating this same method, with a focus on the experiences of women held in long-term immigration detention between 2005 and 2009, was conducted by Rivas and Bull (2018). The authors observed that just under a third (28%) of the sample of 54 women reported having self-harmed. For those held on Nauru, an independent report by Medecins sans Frontieres (2018) found that 34 (16%) of their 208 clients had engaged in self-harm over an 11-month period. When taken together, these studies comprising small sub-sections of the Australian asylum seeker population report self-harm prevalence rates between 16%-36%.

In 2003, the first examination of self-harm rates across the whole Australian onshore detention network was conducted. An analysis of official self-harm figures for asylum seekers in Australian onshore immigration detention between March and October 2001 obtained by the Catholic Commission for Justice, Development and Peace (2001), estimated that self-harm rates for men and women were 12,343 and 10,227 per 100,000, respectively (Dudley, 2003). Calculated self-harm rates in this study were 41 and 26 times the male and female Australian national average. As these comparison figures were, however, calculated in relation to Australian community rates of suicide attempts, rather than self-harm – as captured by the official asylum seeker figures – the limitations of these comparisons, as well as the likely imprecision of the figures, were acknowledged (Dudley, 2003).

More recently, the first systematic examination of all 959 self-harm episodes, and their associated characteristics, reported to the then-called Department of Immigration and

Citizenship (DIAC) – and obtained via Freedom of Information - among adult asylum seekers in Australian onshore immigration detention, found that 22% of asylum seekers self-harmed between October 2009 and May 2011 (Hedrick, 2017). By comparison, a community-based study during the same study period reported six-month self-harm and lifetime prevalence rates of 1.8% and 8%, respectively (Martin et al., 2010; Hedrick, 2017). The calculated self-harm episode rate reported in this study was 224 per 1000 detained asylum seekers (Hedrick, 2017). The four most common methods of self-harm observed were: cutting (47%), attempted hanging (19%), head-hitting (also known as self-battery; 12%), and self-poisoning by medication (6%). Whilst cutting and self-battery were also two of the most commonly reported methods of self-harm in hospital-treated episodes in the general population, attempted hanging was not, accounting for just over 2% of all cases of hospital-treated self-harm during the same reporting period (Hedrick, 2017; Pointer, 2015). This finding highlights that asylum seekers are using more potentially lethal methods of self-harm than the general Australian population. As hanging is strongly associated with an elevated risk of suicide (Runeson, Tidemalm, Dahlin, Lichtenstein, & Långström, 2010), such findings clearly have significant implications for the safety of asylum seekers.

4.7 Precipitating factors for self-harm

Hedrick's (2017) study also investigated the precipitating factors for self-harm among asylum seekers in the Australian onshore detention network, identifying that there were seven main precipitants for self-harm during the 20-month study period. Detention conditions were found to be the most common precipitant (39%), followed by processing arrangements (27%), negative decisions (24%), and family separation (3%). The three remaining, less frequently reported, precipitants were removal processes (1.8%), repatriation arrangements (1.8%), and security clearance processes (1.2%). When taken together, these precipitants can be considered to be mainly modifiable detention-related and procedure-related factors (Hedrick,

2017). Interestingly, these factors are consistent with precipitants for self-harm among other detained populations. Recent research conducted among prisoners in Ireland, for example, documented that the most common triggers for self-harm were detention-specific, such as the physical environment, issues related to accommodation, and legal concerns, and procedure-related factors, such as changes in accommodation or in cells, changes in security level, and relationship concerns regarding family and staff (Irish Prison Service, 2018). Importantly, such factors accord with the largely detention-related and procedure-related factors observed to precipitate episodes of self-harm among asylum seekers detained in Australian-run immigration onshore and offshore detention facilities, as reported in government and other inquiries (ANAO, 2017; Commonwealth Immigration Ombudsman, 2013; Joint Select Committee on Australia's Immigration Detention Network, 2012; Legal and Constitutional Affairs Reference Committee, 2017). Indeed, the conclusions drawn consistently from a number of such inquiries, over several years, are that it is the conditions, practices, and procedures associated with immigration detention which cause significant psychological distress, and, in turn, precipitate self-harm among asylum seekers.

4.8 Perceptions of self-harm

It is important to make mention here of how self-harm among asylum seekers may be perceived by both health professionals and the Australian government. Self-harm in the general population has been considered by clinicians and other allied health providers in some studies to be a form of manipulative behaviour (Peterson et al., 2008; Rees, Rapport, Thomas, John, & Snook, 2014), which has consequences for the type of treatment and support that individuals receive. The Australian government itself has, in fact, frequently characterised asylum seekers who have self-harmed as attempting to manipulate the government into granting them a protection visa, or in the case of those detained in offshore detention, to be brought to Australia (AHRC, 2014; Legal and Constitutional Affairs

Reference Committee, 2017; Willingham & McMillan, 2019). As outlined by clinical experts in Australian government and other inquiries into immigration detention, however, self-harm among asylum seekers is generally observed to occur as a way of managing genuine psychological distress, and not as a form of manipulative behaviour (Commonwealth Immigration Ombudsman, 2013; Legal and Constitutional Affairs Reference Committee, 2017).

Summary of self-harm in asylum seekers, and remaining questions

Epidemiological research regarding self-harm across the Australian asylum seeker population has been very limited. The two extant studies examining self-harm among asylum seekers in Australian onshore immigration detention reported extremely high rates of self-harm, particularly in comparison with the general population. Cutting, self-battery and attempted hanging were the three most common methods of self-harm reported in the latter study, and precipitating factors for self-harm were observed to be largely detention-related and procedure-related factors. Self-harm is commonly understood by clinicians as a way of managing genuine psychological distress, and not as a form of manipulative behaviour. Since the recommencement of offshore processing in 2012, no systematic research into self-harm across the entire Australian asylum seeker population has been conducted. It remains, unknown, therefore, whether or not these trends have continued. It also remains unknown how the rates and key characteristics of self-harm might compare to those among asylum seekers in community-based arrangements, community detention, or onshore detention.

4.9 Self-harm monitoring and reporting

The lack of systematic research into self-harm in the Australian asylum seeker population can be attributed, to a considerable extent, to the Australian government's self-harm monitoring and reporting practices (Hedrick, 2017). The Australian government collects data on all self-harm incidents that occur across the Australian asylum seeker population, and some data are

made available under certain circumstances, such as parliamentary inquiries. However, immigration authorities do not routinely monitor, compile, analyse or report such data, and therefore cannot use these data to improve efforts to prevent and respond to incidents of self-harm (Hedrick, 2017). A number of parliamentary and independent reports corroborate this state of affairs, citing problems with the Department of Immigration's information management and reporting processes, as well as the lack of independent monitoring of their self-harm reporting practices (ANAO, 2017; Joint Select Committee on Australia's Immigration Detention Network, 2012; Legal and Constitutional Affairs Reference Committee, 2017).

As highlighted by the WHO (2014), regular surveillance of self-harm, particularly among at-risk populations, is fundamental for developing and implementing evidence-based self-harm prevention and intervention strategies. Indeed, as asserted by the WHO (2016) in their practice manual for countries wishing to establish, maintain or improve their self-harm surveillance and monitoring systems, improving the quality of data collected can help to inform the most appropriate setting-specific interventions, as well as universal self-harm prevention strategies. This includes prevention strategies located at the public policy level. As increased knowledge about the rates and key characteristics of self-harm across the Australian asylum seeker population may help to inform both policy and practice development, the investigation of self-harm among asylum seeker populations should be made a public health priority.

4.10 Summary and thesis aims

This literature review – undertaken across Chapters 3 and 4, and in the context of the policies governing Australia's treatment of asylum seekers, as outlined in Chapter 2 – has highlighted the need to know more about the epidemiology of self-harm among asylum seekers, in order to inform the development of self-harm prevention strategies, and to improve governmental

and clinical responses to self-harm among asylum seekers. As outlined in Chapter 1, across four distinct studies concerning asylum seekers in both detention and community-based settings, this thesis aims to:

1) Evaluate the quality of self-harm incident reporting across the entire Australian asylum seeker population;
2) Ascertain the incidence of self-harm among the Australian asylum seeker population;
3) Identify the characteristics associated with self-harm among the Australian asylum seeker population;
4) Determine whether episode rates and characteristics of self-harm vary according to processing arrangements (i.e., community-based arrangements, community detention, onshore detention, offshore detention [Nauru], and offshore detention [Manus Island]), and gender;
5) Determine whether episode rates and method(s) of self-harm in the Australian onshore detention network vary according to held detention type (i.e., whether asylum seekers are housed in Immigration Detention Centres [IDCs], Immigration Transit Accommodation [ITA], Immigration Residential Housing [IRH], or Alternative Places of Detention [APODs]);
6) Examine how the distribution of self-harm, and methods used to self-harm across the Australian asylum seeker population, vary according to the 24-hour cycle, day of the week, and month of the year, including by processing arrangements.

Chapter 5: Methods

5.1 Study design

The current study is a mixed methods study, combining the analysis of quantitative and qualitative data extracted from all self-harm incidents reported as occurring across the Australian asylum seeker population from 1 August 2014 to 31 July 2015, in order to evaluate the quality of self-harm reporting, and to examine the episode rates and key characteristics of self-harm among asylum seekers. Ethics approval for this study was obtained from the University of Melbourne's Human Research Ethics Committee (#1749949.1).

The methodological approach used in this thesis is content analysis (Elo & Kyngas, 2008), a technique that allows the researcher to qualitatively analyse documents or texts in a systematic way, in order to identify, categorise, and analyse themes (Cresswell, 2003). The technique also allows the researcher to then quantify the themes or categories that are identified **(**Vaismoradi, Turunen & Bondas, 2013).

In this thesis, and the publications arising from it, content analysis is utilised as a method for identifying, describing, and categorising a number of key characteristics associated with self-harm among the Australian asylum seeker population. The categories of characteristics identified in the content analysis process undertaken for the purposes of this research were then also quantified in order to determine the incidence of these characteristics, as well as the overall incidence of self-harm. Given the established need to know more about the epidemiology of self-harm among asylum seekers – as outlined in **Chapter 4 – Self-harm** - the ability to both describe categories of key self-harm characteristics, as well as to determine their incidence, was considered to be particularly useful for advancing understandings in this under-studied field of research. An overview of the data source, as well as the content analysis process the PhD candidate used to create the unique self-harm dataset used in this

thesis, is outlined below. Chapters 6-9, which contain the four main studies presented in this thesis, also provide further descriptions of the methodologies utilised in each paper.

5.2 Dataset: Self-harm incident reports

The self-harm dataset used to answer the six main research questions in this thesis was extracted and created from scratch by the PhD candidate from all self-harm incidents reported as occurring among the Australian asylum seeker population in the 12 months between 1 August 2014 and 31 July 2015. As stated earlier, whilst the Australian government do collect data (via self-harm incident reports completed by detention and community-based staff and contractors) on all self-harm incidents that occur across the Australian asylum seeker population, they do not routinely monitor, extract, analyse or report on such data. This means that they cannot use the knowledge that may be derived from the analysis of such data – the only available self-harm data – for improved prevention and response. In 2016, the Australian government was compelled to release all self-harm incidents reported as occurring among asylum seekers from 1 August 2014 to 31 July 2015, via Freedom of Information (FOI) laws. This was the largest set of self-harm incident reports ever released from across the entire Australian asylum seeker population, and the first since the resumption of offshore processing. As no comparable data have been released in the interim, this represented a unique opportunity to evaluate the quality of self-harm reporting, and to examine the episode rates and key characteristics of self-harm among the Australian asylum seeker population, in order to improve the evidence-based management and prevention of self-harm in asylum seekers. Put differently, the release of these incident reports represented a novel opportunity to overcome a significant methodological constraint in self-harm research with asylum seekers, as highlighted in **Chapter 4 – Self-harm**: how can we learn more about the epidemiology of self-harm among the Australian asylum seeker population without access to population-wide data? Indeed, as further outlined in **Chapter 4, Section 4.6 – Self-harm in**

asylum seekers, whilst there have been a handful of studies examining self-harm in small sub-sections of the Australian asylum seeker population, no epidemiological research has been conducted into self-harm across the entire Australian asylum seeker population since the recommencement of offshore processing in 2012. Prior to that time, as also noted in **Chapter 4 – Self-harm**, only two studies have examined self-harm among asylum seekers in Australian onshore immigration detention. Given this identified lack of epidemiological research, the systematic investigation of these data from across the entire Australian asylum seeker population - undertaken for the purposes of this thesis - represents an original and substantial contribution to knowledge about self-harm among asylum seekers.

As noted in Chapters 1 and 4, self-harm includes all forms of intentional self-injury (or self-poisoning), irrespective of suicidal intent or motivation (Hawton et al., 2003). In this context, a self-harm incident is an event involving an asylum seeker in one of Australia's onshore immigration detention facilities, offshore processing centres, in community detention, or living in community-based arrangements. According to the incident report matrix provided to staff and contractors released on the DIBP's (2017) FOI disclosure log, self-harm incident reports are supposed to include a short summary or description of the self-harming incident, including the method(s) used, the location of the incident, the injury inflicted, as well as any action(s) taken. Self-harm incidents are required to be reported verbally by staff or service providers to a duty manager within 30 minutes, and in writing on an incident report form within three hours (Commonwealth Immigration Ombudsman, 2013). These reports are then filed in a centralised incident management log or portal by the DIBP. The incident reports available for analysis relate to episodes of self-harm, and do not include suicide.

5.3 Ethics

For the present study, all self-harm incidents reported as occurring in the 12 months between 1 August 2014 and 31 July 2015 were obtained by the PhD candidate after they were released

under the *Freedom of Information Act*, and published on the DIBP's (2017) FOI disclosure log. Whilst the original self-harm incident reports were released after being found to meet the Public Interest Test (Office of the Australian Information Commissioner Freedom of Information: conditional exceptions, 2016), meaning they were de-identified, publicly accessible documents, this did not mean that were no ethical issues to consider prior to conducting this research. Potential ethical risks that were considered and addressed include: the safety of the data collector, the management and monitoring of the project under the supervision of the responsible researcher and the supervisory team, data storage, as well as ensuring that no individuals could potentially be identified in this thesis or any associated publications, though all data were anonymous (see Section 5.4 below). As stated earlier, ethics approval for this research was obtained from the University of Melbourne's Human Research Ethics Committee (#1749949.1).

5.4 Additional ethical considerations

Whilst the current study did not involve collecting self-harm data directly from asylum seekers, instead extracting, creating, and analysing a unique self-harm dataset developed via content analyses from the Australian government's archived self-harm incident reports – not previously systematically extracted, analysed or reported on by the government – it is important to outline the steps taken to protect the confidentiality and anonymity of the asylum seekers concerned. Indeed, all asylum seekers have a legitimate expectation of privacy concerning information that might identify them, and all reporting (of incidents associated with asylum seekers) must respect this (Farrell, Bull & Bacon, 2013). Firstly, all names, dates of birth, personal identification numbers of asylum seekers (also known as 'boat arrival numbers' or 'boat IDs'), ages, nationalities, and other potentially identifying details were redacted from the self-harm incident reports prior to being released under *Freedom of Information* (Cth) and the reports being made available to the public, meaning that the self-

harm data are anonymous. Secondly, all of the self-harm incident reports were further inspected by the PhD candidate prior to the coding process, as a technical check, to ensure that they were completely de-identified before being identified only by a code. These steps are consistent with those undertaken by the Moss Review (2015) to protect the identity of asylum seekers.

5.5 Procedures

The first step in the content analysis process used to conduct the body of research in this thesis involved manually searching the self-harm incident reports in order to identify all incidents categorised as involving self-harm. The incident reports obtained via FOI were not fully searchable by electronic means, so the initial search for incidents categorised as self-harm needed to be conducted manually by the PhD candidate. When released under FOI laws, the incident reports were originally grouped into four quarters over the 12-month period, designated Q1 to Q4. The number of self-harm incidents in each of the four quarters were therefore first identified and summed by the PhD candidate, before being aggregated to establish both the total number of self-harm incident reports per quarter, as well as annually. This process conducted by the PhD candidate yielded a total of 949 self-harm incidents.

Guided by the literature, descriptive information was then extracted by the PhD candidate from each self-harm report, using content analysis. Each self-harm incident was categorised – by the candidate - according to time of self-harm episode, day of the week, month, processing arrangement (i.e., community-based arrangements, community detention, onshore detention, offshore detention (Nauru), and offshore detention (Manus Island)), closed onshore detention type (where relevant, i.e., IDCs, ITAs, IRH, and APODs), individual detention facility name, method(s) of self-harm used, and gender. Following coding processes for content analysis (Elo & Kyngas, 2008), all self-harm incident reports were read at least three times before descriptive information was extracted and recorded.

Categorisation of processing arrangement, closed onshore detention type, and individual detention facility was conducted according to the details contained in each incident report. Time, date and month of self-harm episode were obtained by the PhD candidate from the information routinely entered on each incident report. SPSS version 24 was used to extrapolate and identify the day of the week for each self-harm incident from this information. Time of self-harm incident was then also divided into six 4-hour intervals: 12:00 AM–3:59 AM, 4:00 AM–7:59 AM, 8:00 AM–11:59 AM, 12:00 PM–3:59 PM, 4:00 PM–7:59 PM, and 8:00 PM–11:59 PM for the purposes of Study 4, as further described in Chapter 9. Details regarding methods used to self-harm (including site of injury on body, medication type, medication quantity, chemicals and foreign objects ingested, where provided and appropriate) were identified, categorised, and extracted by the PhD candidate from the free text in the incident reports. As no gender tick box was included on the self-harm incident reports, gender was coded by the candidate following a qualitative analysis of the text in each report. Terms such as ‘she’, ‘her’, ‘hers’, ‘female’ and ‘woman’ and ‘he’, ‘him’, ‘his’, ‘male’ and ‘man’ were, for example, used to categorise gender. Cases where gender was not able to be determined were classified as a separate category of ‘gender not known’. An independent coder was used to assess the way a sub-sample of 100 incident reports were categorised, as a reliability check. The inter-rater reliability was found to be very high (kappa = 0.95) (McHugh, 2012).

Study 1, as further described in chapter 4, presents findings from a quality assessment undertaken in order to evaluate each self-harm incident against the core WHO (2016) self-harm reporting guidelines. The coding framework for core self-harm data items outlined in the WHO’s (2016) ‘Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm’ was used to assist the PhD candidate in identifying all relevant reporting characteristics, in addition to those described above. This included core

data items related to the medical severity and clinical management of self-harm incidents (e.g., psychological/psychiatric assessment, use of ambulance or medevac, admission to hospital). Studies 2-4, presented in chapters 5-7, were conducted using the main self-harm dataset extracted from the self-harm incident reports by the PhD candidate, as outlined in the preceding paragraphs.

When taken together, this comprehensive content analysis process resulted in the development of a globally unique self-harm dataset, specifically built for the purposes of this body of research. Given the identified lack of epidemiological research into self-harm across the entire Australian asylum seeker population – as highlighted above, and in **Chapter 4 – Self-harm** - the development of this novel dataset via content analyses is a substantial and innovative methodological achievement of its own.

5.6 Data analysis

All data were entered into SPSS version 24 by the PhD candidate. As noted above, an independent assessor was, however, first used to assess a sample of 100 incident reports as a reliability check. The inter-rater reliability was found to be very high (kappa = 0.95) (McHugh, 2012), and on that basis all remaining events were coded by a single coder.

The statistical analyses varied according to each research question, although they were mainly descriptive, and adapted to the available data. Chapters 6-9, which contain the four main studies presented in this thesis, provide further descriptions of the analyses conducted in each paper. Chi-square tests were used to establish differences between proportions, where cell counts permitted. Given the incident reports capture episodes, rather than individuals, episodes are used as the basis of analysis in this thesis, not individuals. In Studies 2-3, the annual episode rate of self-harm per 1000 asylum seekers was calculated for each asylum seeker population according to processing arrangement, held onshore detention type (where relevant), as well as each onshore facility comprising each detention type, using the average

adult population figures for the 12-month period, according to the DIBP's (2015b) community and immigration detention statistics, and the Department of Home Affairs (2015) onshore statistics, with 95% confidence intervals (CI) based on Poisson distribution. As population figures are published monthly by the Department of Immigration, the population figures for each of the relevant cohorts were first identified and extracted for each month over the one-year period, before being aggregated and divided by 12 to create average annual population figures. In Study 4, the monthly episode rates of self-harm were also calculated for the total Australian asylum seeker population, as well as the onshore detention population, Nauru and Manus Island, using the average monthly population figures, according to the DIBP's (2015) statistics, with 95% CI, and displayed in section **9.9 Supplementary tables**.

Chapter 6: An evaluation of the quality of self-harm incident reporting across the Australian asylum seeker population according to World Health Organization (WHO) guidelines

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6.1 Abstract

Background: Asylum seekers are at elevated risk of self-harm, and the personal and public health costs of self-harm are high; yet the monitoring and reporting of self-harm has been limited and lacking in transparency. This study aims to evaluate the quality of self-harm incident reporting across the Australian asylum seeker population, including by processing arrangements (i.e., community-based, community detention, onshore detention, Nauru, and Manus Island).

*Methods***:** All self-harm incidents reported across the entire Australian asylum seeker population between 1 August 2014 and 31 July 2015 were obtained via the *Freedom of Information Act*. We assessed the quality of self-harm incident reporting according to the World Health Organization (WHO)'s self-harm reporting guidelines.

Results: A total of 949 self-harm incident reports were assessed. Date, location (processing arrangement), and time of self-harm were routinely reported. Gender was recorded in less than two thirds (62.1%) of all incidents. Method(s) used to self-harm was reported in 81.5% of all incidents, though IDC-10 codes were not reported in any episodes. Psychological or psychiatric assessments were recorded after 4.0% of all incidents, most frequently on Manus Island (10.9%), and in Nauru (10.0%), and least frequently in community-based arrangements (1.7%) and in onshore detention (1.4%), and not at all in community detention. Ambulances were reported as attending 2.8% of all episodes. Hospital attendances were reported following 6.0% of all self-harm incidents, with attendances most commonly reported in incidents occurring in community detention (30.3%), and in community-based arrangements (19.4%). Medevac (air ambulances) were recorded as being utilised in 0.4% of all incidents (2.1% of episodes on Nauru, 1.8% on Manus Island).

Conclusions: The findings of our study indicate that the accessibility and quality of self-harm data is substandard and inconsistent with WHO self-harm reporting guidelines. Such variable

reporting makes the identification of self-harm trends, the implementation of prevention strategies – including those at a policy level - and the clinical management of self-harm, extremely challenging. Improved self-harm reporting and monitoring is urgently needed for mitigating and responding to self-harm risk among asylum seekers.

6.2 Background

The United Nations High Commissioner for Refugees (UNHCR) reports that the number of displaced individuals worldwide now exceeds 70 million [1]. Since 1992, Australia has had a policy of mandatory immigration detention for all 'unlawful non-citizens', the majority of which have been asylum seekers during periods when boat arrivals have been large [2]. This policy has also been extended to offshore processing, most recently reinstated in late 2012. Offshore processing includes the indefinite detention of asylum seekers on the Pacific island nation of Nauru and Manus Island, Papua New Guinea, and precludes their resettlement in Australia [3]. In addition to detaining asylum seekers in both onshore and offshore immigration detention, asylum seekers in Australia may also be held in a form of 'open' detention, commonly known as community detention, or allowed to live in the community, under community-based arrangements [4]. Australia's policy of detaining asylum seekers, and its associated immigration policies, have attracted much national and international attention [5].

There is now a robust body of evidence demonstrating that asylum seekers experience rates of depression, anxiety and post-traumatic stress disorder (PTSD) [6-7] that are many times higher than in the general community. Studies have also observed that the mental health of asylum seekers worsens with time spent in immigration detention [8]. Whilst research has clearly highlighted the adverse effects of both pre-arrival and post-migration stressors on the mental health of asylum seekers, particularly in relation to immigration detention, research regarding self-harm among asylum seekers has been very limited [9]. Given the available

evidence suggests that asylum seekers have many of the known risk factors for self-harm [9-10] and being detained has been found to further increase self-harm risk [11], such research is urgently needed. Furthermore, the costs of self-harm to individuals, families, and at the public level, are high [12]. Increased knowledge about the epidemiology of self-harm among asylum seekers may help to inform policy and practice development, and the investigation of self-harm among asylum seeker populations should therefore be made a public health priority.

The paucity of research into self-harm in the Australian asylum seeker population can be attributed to the self-harm reporting processes of the Australian government [9, 13]. The government does collect data on all self-harm incidents that are reported as occurring across the Australian asylum seeker population, and some data are made available under certain circumstances, such as parliamentary inquiries [14]. However, it appears that the immigration authorities do not routinely monitor, compile, analyse and report such data, and therefore cannot use these data to improve efforts to prevent and respond to incidents of self-harm. As highlighted in the Commonwealth Immigration Ombudsman's [14] report into Suicide and Self-harm in the Immigration Detention Network, for example, there were a number of issues with the data supplied by the then-called Department of Immigration and Citizenship (DIAC), making self-harm prevalence rates and contributing factors difficult to ascertain. A number of parliamentary and independent reports [15-17], all corroborate this finding, citing problems with the Department of Immigration's information management and reporting processes, as well as the lack of independent monitoring of their self-harm reporting practices.

In its 2014 report 'Preventing suicide: a global imperative', the World Health Organization (WHO) [18] identified a number of areas for action by governments around the world. One of the main recommendations was improvement in the quality of data on self-harm and suicide

attempts by responsible state authorities [18]. To this end the WHO subsequently developed guidelines on establishing and maintaining surveillance systems for self-harm and suicide attempts [19]. These guidelines, contained in a detailed practice manual, can be used by countries wishing to establish, maintain or improve their self-harm reporting and monitoring practices. More specifically, the guidelines highlight the core self-harm data items that countries should collect and routinely report in any self-harm surveillance system. The guidelines [19] assert that improvements in the quality of data can inform the development of the most appropriate setting-specific interventions, as well as help to produce more efficient national self-harm prevention programs.

The primary aim of this study was to assess the quality of self-harm incident reporting across the entire Australian asylum seeker population, according to the core WHO self-harm reporting guidelines [19]. A secondary aim was to determine whether the quality of reporting varied by processing arrangements (i.e., community-based arrangements, community detention, onshore detention, Nauru, and Manus Island).

6.3 Methods

Dataset: self-harm incident reports

We conducted a content analysis of all self-harm incidents reported as occurring among the Australian asylum seeker population between 1 August 2014 and 31 July 2015. In this context, a self-harm incident is an event involving an asylum seeker in one of Australia's onshore immigration detention facilities, offshore processing centres, in community detention, or living in community-based arrangements. Self-harm is defined as all forms of intentional self-injury (or self-poisoning), irrespective of suicidal intent or motivation [14]. All self-harm incidents that occur in the Australian asylum seeker population are required to be reported verbally by staff or service providers to a duty manager within 30 minutes, and in writing on an incident report form within three hours [14]. A categorisation (e.g., 'self-harm')

and the incident details, including a description or summary of the incident, are then entered into the Department of Immigration's centralised incident management log, where the self-harm data are stored. According to internal reporting guidelines, the self-harm incident reports are supposed to include a description of the method and nature of the injury, the incident's time and place, and any subsequent action taken [14].

All self-harm incidents were obtained under the *Freedom of Information Act* (FOIA) [20], after being found to meet the public interest test [21] and published on the (then-called) Department of Immigration and Border Protection (DIBP)'s disclosure log [22]. Ethics approval for this study was granted by the University of Melbourne's Human Research Ethics Committee (#1749949.1).

Quality assessment

A quality assessment was undertaken in order to evaluate each self-harm incident against the core WHO self-harm reporting guidelines [19]. The coding framework for core self-harm data items outlined in the WHO 'Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm' [see 19] was used to assist the coder in identifying all relevant reporting characteristics. Gender was coded following a qualitative analysis of the text in each report, as the official self-harm incident reports did not include a gender tick box. Where possible, for example, terms such as 'she', 'her', 'hers', 'female' and 'woman' and 'he', 'him', 'his', 'male' and 'man' were used to code gender. Unique person number, date of birth, age, and country of origin - an optional WHO self-harm reporting item - were not able to be extracted from the incident reports. Such identifying information, if recorded, would have been redacted prior to release under the FOIA. Details pertaining to country of origin for each processing arrangement were, however, instead retrieved from official DIBP statistics [23-24], as well as statistics regarding offshore processing sourced by the Refugee Council of Australia [25]. An independent coder was used to assess the quality

assessment by examining a sample of 100 incident reports, as a reliability check. The inter-rater reliability was found to be very high (kappa = 0.95) [26] and, on that basis, all remaining events were coded by a single coder (KH). All data were entered into SPSS 24 for descriptive analysis.

6.4 Results

Descriptive information

A total of 949 self-harm incidents were reported in the Australian asylum seeker population (Table 6.1). The number of reported self-harm incidents were observed to vary considerably according to processing arrangements (i.e., community-based, community-detention, onshore detention, offshore detention [Nauru], and offshore detention [Manus Island] (Table 6.2). Whilst country of origin could not be determined from the incident reports, official immigration statistics [23-24] highlight that the two main source countries of asylum seekers in onshore detention, community detention, as well as community-based arrangements during the study period were Iran and Sri Lanka. The largest numbers of asylum seekers sent to Nauru and Manus island at this time were from Iran, or were stateless [25]. There were also sizeable numbers of asylum seekers sent to Nauru and Manus Island who were from Sri Lanka, Afghanistan, Pakistan and Iraq [25].

Quality assessment of the self-harm incident reporting according to WHO reporting guidelines

Our analysis found that all 949 self-harm incidents were assigned a unique event number (Table 6.1). The date of self-harm was recorded in all 949 incidents. Day of the week was not recorded for any of the self-harm incidents, although this could be extrapolated from the date of the incident. Information regarding processing arrangements (i.e., community-based arrangements, community detention, onshore detention, offshore detention [Nauru], offshore

detention [Manus Island]) was reported for all incidents. Details regarding the type of accommodation for those in onshore detention (i.e., Immigration Detention Centres [IDCs], Immigration Transit Accommodation [ITAs], Immigration Residential Housing [IRH], and Alternative Places of Detention [APODs] [4]) - an optional WHO self-harm reporting item - were reported in 100% of all (560) onshore episodes. The time of self-harm incident was reported in all 949 cases (Table 6.1).

Gender was reported in 590 (62.1%) of all incidents (Table 6.1). Whilst gender was able to be identified in 100% of self-harm incidents occurring on Manus Island, this was due to the fact that Manus housed only male asylum seekers and the gender composition of the population could therefore be inferred. Gender was most commonly reported in self-harm incidents in Nauru (84.0%), and least commonly in community-based asylum seekers (35.3%) (Table 6.2).

Methods of self-harm were reported in 774 (81.5%) self-harm incidents, although WHO International Classification of Diseases Tenth Revision (ICD-10) codes were not reported for any episodes (Table 6.1). Methods of self-harm were most commonly reported in self-harm incidents occurring on Nauru (93.0%), and most infrequently among self-harm incidents occurring among community-based asylum seekers (48.6%) (Table 6.2).

For incidents involving self-poisoning by chemicals, the type of chemical used was reported in 100% of episodes, although the quantity of chemicals was not recorded in any cases (Table 6.1). For incidents involving self-poisoning by medication, the type of medication was reported in 34 (43.0%) episodes, with incidents occurring in community-based asylum arrangements (63.6%) most frequently recording medication type (Table 6.2). Quantity of medication was also most commonly reported in incidents occurring in community-based arrangements (27.2%), and least commonly in incidents occurring in onshore detention (10.2%).

Medical severity (as defined by the WHO guidelines – see [19]) was reported in 64 (6.8%) of all incidents (Table 6.1). Medical severity was most commonly reported in self-harm incidents occurring in Nauru (22.8%), followed by those on Manus Island (18.1%) (Table 6.2). Information about who the individual was seen by following the self-harm incident (e.g., general practitioner, nurse, mental health team, police officer, medical clinic staff member) was reported in 24.4% of all episodes. Psychological or psychiatric assessments were reported as occurring in 4.0% of all self-harm episodes, most frequently on Manus Island (10.9%) and in Nauru (10.0%), and least frequently in community-based arrangements (1.7%) and in onshore detention (1.4%), and not at all in community detention (Table 6.2). No diagnoses associated with individuals or prior history of self-harm were reported in any incident reports.

Ambulances were reported as attending 2.8% of all self-harm incidents (Table 6.1). Medevac (medical evacuations or air ambulances) were reported as being utilised in 0.4% of all episodes. Individuals were reported as being taken to hospital in 6.0% of all self-harm incidents. Information about hospital admissions was not reported. Hospital attendances were most commonly reported in incidents among those held in community detention (30.3%), followed by incidents occurring in community-based arrangements (19.4%) (Table 6.2).

Table 6.1

Quality assessment of reporting of all self-harm incidents in the Australian asylum seeker population between 1 August 2014 and 31 July 2015, according to WHO self-harm reporting guidelines

Core WHO self-harm data items	***N* = 949***
Basic details of the incident	
Unique Event #	949 (100%)
Hospital or medical centre #	0 (0%)
Sex	590 (62.1%)
State/Country	949 (100%)
Date of SH	949 (100%)
Day of week of SH	0 (0%)
Time of SH	949 (100%)
Primary Location of SH incident	949 (100%)
Methods of self-harm	
Methods of SH	774 (81.5%)
ICD-10 Codes	0 (0%)
Multiple methods of SH listed	31 (3.3%)
If intentional self-poisoning (chemicals), name of poison	57/57 (100%)
Quantity of poison	0 (0%)
If Intentional self-poisoning (medication), name of poison	34/79 (43.0%)
Quantity of medication	0 (0%)
Type of foreign object ingested	27/28 (96.4%)
Quantity of foreign object	22/28 (78.5%)
Medical severity and response	
Medical severity	64 (6.8%)
Seen by?	232 (24.4%)
History of self-harm (previous self-harm)	0 (0%)
Psychological/psychiatric assessment	34 (4.0%)
Diagnosis (any diagnosis associated with the person)	0 (0%)
Taken to hospital	56 (6.0%)
Ambulance attended	27 (2.8%)
Medevac	4 (0.4%)

*Unless otherwise specified. SH: Self-harm. Values are presented as number (%).

Table 6.2

Quality assessment of reporting of all self-harm incidents in the Australian asylum seeker population between 1 August 2014 and 31 July 2015, according to WHO self-harm reporting guidelines, by processing arrangements

Core WHO self-harm data items	**Community-based n=113**	**Community detention n=33**	**Onshore detention n=560**	**Nauru n=188**	**Manus Island n=55**
Basic details of the incident					
Unique Event #*	113 (100%)	33 (100%)	560 (100%)	188 (100%)	55 (100%)
Hospital or medical centre #	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Sex	40 (35.3%)	16 (48.4%)	321 (57.3%)	158 (84.0%)	55 (100%)
State/Country	113 (100%)	33 (100%)	560 (100%)	188 (100%)	55 (100%)
Date of SH	113 (100%)	33 (100%)	560 (100%)	188 (100%)	55 (100%)
Day of week of SH	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Time of SH	113 (100%)	33 (100%)	560 (100%)	188 (100%)	55 (100%)
Primary Location of SH incident	113 (100%)	33 (100%)	560 (100%)	188 (100%)	55 (100%)
Methods of self-harm					
Methods of SH	55 (48.6%)	25 (75.7%)	470 (83.9%)	175 (93.0%)	49 (89.0%)
Methods of SH with ICD-10 Codes	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Multiple Methods of SH listed	6 (5.3%)	0 (0%)	15 (2.6%)	10 (5.3%)	0 (0%)
If Intentional self-poisoning, name of poison (chemicals)	1/1 (100%)	1/1 (100%)	25/25 (100%)	29/29 (100%)	1/1 (100%)
If Intentional self-poisoning, quantity of chemicals	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
If Intentional self-poisoning, name of poison (medication)	14/22 (63.6%)	2/4 (50%)	7/39 (17.9%)	4/12 (33.3%)	1/2 (50%)
If Intentional self-poisoning, quantity of medication	6/22 (27.2%)	1/4 (25.0%)	4/39 (10.2%)	0 (0%)	0 (0%)
Type of foreign object ingested	-	-	10/10 (100%)	10/10 (100%)	7/8 (87.5%)
Quantity of foreign object ingested	-	-	6/10 (60.0%)	10/10 (100%)	5/8 (62.5%)
Medical severity and response					
Medical severity	2 (1.7%)	0 (0%)	9 (1.6%)	43 (22.8%)	10 (18.1%)
Seen by?	28 (24.7%)	11 (33.3%)	30 (5.3%)	125 (66.4%)	38 (69.9%)
History of SH	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Psychological/psychiatric assessment	2 (1.7%)	0 (0%)	8 (1.4%)	18 (10.0%)	6 (10.9%)
Diagnosis (any diagnosis associated with the person)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Taken to hospital	22 (19.4%)	10 (30.3%)	13 (2.3%)	11 (5.8%)	0 (0%)
Ambulance attended	0 (0%)	0 (0%)	0 (0%)	26 (13.8%)	1 (1.8%)
Medevac	0 (0%)	0 (0%)	0 (0%)	4 (2.1%)	1 (1.8%)

***** For incidents occurring in onshore detention, community detention, and community-based arrangements, the unique event number was termed 'incident number'. Incidents occurring in Nauru and Manus Island were given unique Planning and Operational Management System [POMS] ID numbers. POMS was the new centralised database for recording incidents introduced during this period [15]. SH: Self-harm. Values are presented as number (%).

6.5 Discussion

The WHO [18] asserts that surveillance of self-harm is an essential element of national self-harm prevention strategies. It also highlights that improvement in the quality and availability of self-harm data is likely to be needed for all countries [19]. The findings of our study confirm that there are substantial gaps in both the quality and availability of self-harm data across the Australian asylum seeker population, and that there is a very low level of compliance with WHO self-harm reporting guidelines.

Basic details of the incident

Whilst basic details (incident number, date, location (processing arrangement), and time of self-harm) were routinely reported in all self-harm incidents, the majority of the core WHO self-harm data items were reported in a limited and inconsistent fashion. Reporting was also found to vary considerably according to processing arrangements. It is not known why reporting on gender, for example, was found to be so poor, including across processing arrangements, however the lack of a gender tick box on the self-harm incident reports would have almost certainly made it difficult for such information to be captured efficiently. As women have previously been found to be over-represented in self-harm incidents [27], particularly in detention settings [28], and gender-based differences in the use of method(s) used to self-harm have also been identified [27], improved reporting on gender in self-harm incidents among asylum seekers, including across all sub-populations, is clearly needed to better identify relevant gendered trends in self-harm, as well as prevention measures. Including a gender tick box on all self-harm incident reports would be likely to contribute to a substantial improvement in reporting on gender in future.

Method(s) used to self-harm

According to the WHO [19], the classification of self-harm according to IDC-10 codes ensures that the data are more easily transferrable and can be used to inform national and international self-harm surveillance strategies. The fact that IDC-10 codes were not recorded in any self-harm incidents in our study may therefore have impeded any attempts to make potentially useful comparisons with other national and international populations of relevance, for example, prison populations, as well as the general Australian community. Furthermore, method(s) used to self-harm should have been reported for each self-harm incident, in order to better respond to risk, including through WHO recommended prevention strategies [19], such as means reduction. Without the tracking of trends in method(s) used to self-harm, such strategies clearly cannot be implemented.

Method(s) used to self-harm were also found to be reported inconsistently across the various processing arrangements. The frequency of reporting of method(s) used to self-harm among community-based asylum seekers – the lowest observed across all Australian asylum seeker populations - is likely to be reflective of the type of contact that asylum seekers under such arrangements have with their appointed case workers [29]. That is to say, due to their infrequent contact with their clients, case workers may not have been made aware of the method(s) used, or have inquired about the methods(s) used, and therefore were not able to report such information. It is also possible that case workers may have been notified that a self-harm incident had occurred via a third party (e.g., a health professional, or hospital social worker), but that they were not privy to the confidential details regarding the incident itself.

The quality of reporting in regards to self-poisoning (by both medication and chemicals) in the present study was also found to be particularly poor. Such variable reporting across the entire population makes the identification of self-harm trends, the implementation of means reduction strategies, and the clinical management of self-harm, extremely challenging.

Improved reporting of method(s) used to self-harm across the asylum seeker population, including by sub-populations, as well as details regarding the name and quantity of medication and/or poison ingested, is urgently needed for mitigating and responding to future self-harm risk among asylum seekers.

Medical severity and response

Whilst the Royal Australian and New Zealand College of Psychiatrists (RANZCP) practice guidelines [30] espouse that 100% of individuals who require or present for treatment following an episode of self-harm should undergo psychosocial assessments, such assessments were reported in just 4.0% of all self-harm incidents in the current study. Previous research regarding hospital-treated self-harm has also observed low levels of compliance with similar (United Kingdom) recommendations regarding psychosocial assessments [31-32], however assessments occurred in 30%- 50% of episodes, depending on time of day. This represents a rate 7 to 12-fold higher than that reported in the present study. It is possible that psychosocial assessments did occur in relation to the self-harm incidents we reviewed, but were simply not reported, or that they were conducted, but outside the three-hour reporting period. Regardless of whether or not this is the case, these reporting practices can still be deemed highly problematic as they would have impeded the systematic identification of self-harm trends and prevention measures. Indeed, research regarding hospital-treated self-harm has found that repetition of self-harm is higher among individuals who have not received a psychosocial assessment compared with than those who have [33]. Consequently, it may be that the practice of not providing a psychosocial assessment may have exacerbated, rather than reduced, levels of psychosocial distress.

The pattern of reporting observed in regard to hospital attendances – most common in community-based asylum seekers - may reflect the availability and closer proximity of hospitals in mainland Australia. It may also reflect the fact that there are some on-site

medical facilities in onshore and offshore immigration detention, rather than the lack of need for hospital treatment in these settings [3, 34-35]. Access to appropriate medical treatment has previously been found to be particularly lacking in offshore detention [3, 34-35]. Indeed, medevac (or air ambulances) were only utilised in incidents occurring in Nauru and on Manus Island, which is conceivably due to the remote geographical location of both islands, as well as the reduced capacity of services to respond to particular medical needs and/or emergencies in these settings [3, 34-35].

The inconsistencies in reporting observed across all processing arrangements likely highlight the fact that a variety of different service providers and government contractors are engaged to provide healthcare, welfare, support and security services across the Australian asylum seeker population, resulting in variable levels of service, as well as reporting and other practices. Indeed, as outlined in the Auditor General's report into garrison and welfare support [16], as well as the Australian Lawyer's Alliance report [36] regarding general incident reporting during a similar period, there were a number of inconsistencies in reporting practices and processes observed across different processing arrangements. These were found to arise due to a lack of appropriate information management processes, the ability to engage and retain staff (particularly in offshore detention), and ad-hoc responses to operational events [16]. Perhaps most critically, such inconsistencies were also attributed to differing understandings of what constitutes a notifiable incident, as well as the relationship between incident reporting and risk mitigation. Self-harm (and other) incident reporting and management should be standardised, as recommended by the WHO [19], with formal training provided at regular intervals across all processing arrangements. The findings of the current study call into question the level of information and training provided to staff and contractors regarding incident reporting, as well as responding to, and mitigating, risk.

Practice implications

Our findings point to the urgent need to institute independent monitoring and surveillance of self-harm in the Australian asylum seeker population. Such monitoring should be transparent and conducted by an independent body of clinical experts who have the statutory power to investigate self-harm among asylum seekers and refugees in both onshore and offshore immigration detention arrangements, as well as in community-based settings. The Australian Medical Association (AMA) has long advocated for the creation of a national statutory body of clinical experts with the power to investigate the health and wellbeing of asylum seekers and refugees [37]. The independent monitoring of self-harm in asylum seekers could potentially form part of the responsibilities of an authority of this kind, with reporting conducted in line with WHO self-harm guidelines [19].

Regular data analysis, tracking and formal reporting of trends in self-harm should also occur, in order to help identify prevention measures, and to assist with clinical management and means reduction strategies. In keeping with the WHO self-harm guidelines [19], the annual incidence rate per 1000 asylum seekers (rather than per 100,000, given the size of the population/s in question) should be calculated for the total Australian asylum seeker population, and disaggregated by gender, processing arrangements, and other subpopulations, based on average annual adult population figures. These population figures can be extracted from statistics the Department of Home Affairs regularly compiles on the number of asylum seekers in both onshore and offshore detention, as well as in community detention, and community-based arrangements [23-24]. Individual rates of self-harm should be calculated in addition to episode rates of self-harm - as well as 95% confidence intervals (CI) for each of the rates - in order to distinguish between the number of individuals self-harming and the total number of self-harm incidents. As per the WHO guidelines [19], the analysis and reporting of self-harm rates, trends (such as in method(s) used to self-harm), and relevant

comparisons (e.g., by gender, or sub-populations) should occur on a quarterly basis. Such reporting could then be used to inform the Commonwealth Government, the UNHCR, the Australian Human Rights Commission, relevant health bodies (e.g., RANZCP), as well as other agencies, such as the private contractors and service providers, (e.g., International Health and Medical Services), which manage or work within the immigration detention network.

In addition to the independent monitoring and reporting of self-harm, a mechanism to ensure that psychosocial assessments are provided for all asylum seekers following every self-harm incident should be established. The regular monitoring of such assessments, as well as any follow-up, could also be conducted by an independent statutory body of clinical experts. Such a mechanism may assist in reducing both self-harm repetition [33], and suicide risk [32], as found in previous research.

The inconsistencies in the quality and breadth of reporting found between all processing arrangements in the present study also highlight the need for standardised training in self-harm reporting for staff and contractors to be implemented across the Australian asylum seeker system. Such training should be provided at regular intervals and include a component on the relationship between incident reporting and risk mitigation. It should also be provided by an independent body. This will help to ensure that a standardised approach to, and understanding of, self-harm incident reporting and risk mitigation is established across the whole asylum seeker population.

Strengths and limitations

Our study had a number of strengths. First, these are the first published data examining the self-harm reporting practices across the Australian asylum seeker population according to the core WHO self-harm reporting guidelines. Second, we were able to access - via the FOIA –

all self-harm incidents reported across the Australian asylum seeker population over the one-year study period. Finally, our sample was large and enabled us to assess not only the quality of self-harm reporting across the Australian asylum seeker population as a whole, but also the quality of reporting practices according to each of the five main processing arrangements (i.e., community-based asylum arrangements, community detention, onshore detention, offshore detention [Nauru], and offshore detention [Manus Island]).

Our study also had some limitations. The number of unreported episodes of self-harm over the course of the study is not known. As most self-harm is not followed by help-seeking behaviour [38], it is highly likely that the number of self-harm episodes reported represents an under-estimate of the true incidence of self-harm occurring across the Australian asylum seeker population. Furthermore, inquiries and independent reports into conditions and practices in immigration detention have highlighted a number of inconsistencies with incident reporting practices, including cases where incident reports have been destroyed [15-16, 36]. The current study sought to assess the quality of self-harm reporting according to the core WHO self-harm reporting guidelines [19]. Only data items that were reported as occurring could be assessed. It is possible, therefore, that whilst particular services or responses, for example, psychosocial assessments, or ambulance attendances, were not reported, they did actually occur. It is also possible that additional core self-harm data may have been contained in the hard copies of the self-harm incident reports that the service providers are initially required to complete, prior to entering the incident details directly into the Department of Immigration's centralised incident management system. As reported by the Department of Immigration on their FOI disclosure log in response to requests for such data [22], however, these incident reports fail to meet the 'public interest test' [21] - which would permit their release under the FOIA - because the documents contain 'substantially the same subject matter' [22] to that entered and held on the Department of Immigration's centralised incident

management log, and from which it draws its official self-harm data. An inspection and comparison of 20 hard copies of the incident reports (released by a 'whistle-blower') with the relevant reports from the study period entered into the Department of Immigration's critical incident data management system by the authors confirms this: no additional core WHO self-harm data were able to be extracted from such reports. Finally, as the self-harm incidents occurred in 2014-2015, the age of these data could also potentially be considered a limitation. This was, however, the largest set of self-harm data from across the entire Australian asylum seeker population ever made publicly accessible. Furthermore, as no additional self-harm data has been freely released by the government or under FOIA laws in the intervening period, these data remain the largest, and the only currently accessible self-harm dataset from across the entire Australian asylum population.

6.6 Conclusions

The findings of our study indicate that the accessibility and quality of self-harm data is substandard and inconsistent with WHO self-harm reporting guidelines. They also highlight a number of inconsistencies in the quality and breadth of self-harm reporting between all processing arrangements. Such variable reporting across the entire asylum seeker population makes the identification of self-harm trends, the implementation of prevention strategies – including those at a policy level - as well as the clinical management of self-harm, extremely difficult. Improved reporting is urgently needed in order to mitigate and respond to self-harm risk in the Australian asylum seeker population. Regular monitoring, as well as standardised training, should be implemented as an urgent public health priority. The monitoring of self-harm should be conducted by an independent body of clinical experts who have the statutory power to investigate self-harm among asylum seekers in both detention and community-based settings.

Abbreviations

AMA: Australian Medical Association

APOD: Alternative Places of Detention

CI: Confidence Intervals

DIAC: Department of Immigration and Citizenship

DIBP: Department of Immigration and Border Protection

FOI/A: Freedom of Information Act

ICD-10: WHO International Classification of Diseases Tenth Revision

IDC: Immigration Detention Centre

IRH: Immigration Residential Housing

ITA: Immigration Transit Accommodation

Medevac: Medical evacuation (or air ambulance)

PTSD: Post-traumatic Stress Disorder

RANZCP: Royal Australian and New Zealand College of Psychiatrists

SH: Self-harm

UNHCR: United Nations High Commissioner for Refugees

WHO: World Health Organization

Declarations

Ethics approval

Ethics approval for this study was obtained from the University of Melbourne's Human Research Ethics Committee (#1749949.1). The research was therefore performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments. The self-harm incident reports used for analyses were already de-identified and all analyses took place at an aggregate level.

Consent for publication

Not applicable.

Availability of data

The dataset that support the current findings was generated by data that are publicly available on the Department of Home Affairs' Freedom of Information Disclosure log at: https://www.homeaffairs.gov.au/access-and-accountability/freedom-of-information/disclosure-logs.

Competing interests

KH is the founder of Community-Minded Psychological Services, a private practice for people from immigrant, asylum seeking and refugee backgrounds in Melbourne, Australia, which has received funding from the Australian government to provide psychological support to asylum seekers. GC is employed at the Victoria Foundation for Survivors of Torture (Foundation House), an organisation which receives funding from the Australian government to provide psychological assistance to asylum seekers, including those in immigration detention. GC has been contracted by the Australian government's Department of Home Affairs to provide training in relation to the psychological aspects of refugee status determination. KH has been contracted by the Australian government's Department of Home

Affairs to conduct independent mental health assessments and write psychological reports for the purposes of refugee status determination for asylum seekers who have been detained in offshore detention. This research was conducted in their personal capacity, however, and the views expressed here are their own, and those of their co-authors. RB and GA declare that they have no conflicts of interest.

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Authors' contributions

KH conceived of the study, in conjunction with GA, and with guidance from RB and GC. KH collected the data, conducted the analyses and wrote the first draft of the manuscript. All authors provided comments and feedback to refine subsequent drafts, and read and approved the final manuscript.

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Chapter 7: Part one - Self-harm in the Australian asylum seeker population: A national records-based study

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7.1 Abstract

Background: Systematic research into self-harm in the Australian asylum seeker population is scarce, largely due to the lack of accessible data. The aim of this study was to examine the incidence and characteristics of self-harm across the Australian asylum seeker population, and to ascertain whether self-harm rates and characteristics vary by processing arrangements (i.e., community-based arrangements, community detention, onshore detention, offshore detention (Nauru), and offshore detention (Manus Island)), and gender.

*Methods***:** Data relating to the incidence of self-harm, method(s) used to self-harm, processing arrangements, and gender were extracted from all self-harm incidents recorded as occurring among the Australian asylum seeker population between 1 August 2014 and 31 July 2015. Self-harm episode rates were calculated using the average estimated adult population figures for the 12-month period for each asylum seeker population.

Results: 949 self-harm episodes were included in the analyses. Rates ranged from 5 per 1000 asylum seekers in community-based arrangements to 260 per 1000 asylum seekers in offshore detention in Nauru. Rates were highest among asylum seekers in offshore and onshore detention facilities, and lowest among asylum seekers in community-based arrangements and community detention. The most common methods of self-harm were cutting (37%), self-battery (26%), and attempted hanging (11%), with asylum seekers in held detention using a wider variety of methods than those in community-based arrangements and community detention.

*Conclusions***:** Our findings highlight the exceptionally high rates of self-harm among detained asylum seekers compared to rates observed in the general Australian population, and among asylum seekers in community-based settings. These findings point clearly to the deleterious impact of immigration detention, and warrant urgent attention.

Definitions. Article 1A(2) of the Refugee Convention defines a *refugee* as 'a person who has 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 (their) nationality, and is unable, or owing to such fear, is unwilling, to avail (themselves) of the protection of that country' (UNHCR, 2010, p.14).

The term *'asylum seeker'* is often used interchangeably with refugee, but it has a different legal definition. An asylum seeker is a person who is seeking 'protection, but whose claim for refugee status has not yet been assessed' (Phillips, 2015, p.3). Under international law, however, a person is a *refugee* as soon as they meet the definition of a refugee, whether or not their claim has been assessed. If they are subsequently found to be refugees, then they are 'recognised refugees' (Refugee Council of Australia, 2015).

7.2 Introduction

Current conflicts are creating an increase in forced migration worldwide, with the number of individuals fleeing persecution, war and violence reported to have surpassed 68.5 million (UN High Commissioner for Refugees, 2017). Increasingly restrictive 'policies of deterrence' (Robjant, Hassan & Katona, 2009) have been established by Australia, as well as many other western countries, in a bid to curtail the entry of asylum seekers. The Australian government has had a policy of mandatory, indefinite immigration detention for asylum seekers arriving by boat, referred to as illegal maritime arrivals (IMAs), since 1992 (Phillips & Spinks, 2013). In late 2012, the Australian government resumed offshore processing for IMAs - a policy successive governments had maintained between 2001-2008 - meaning that asylum seekers who arrived by boat were liable to be transferred to the Pacific island nation of Nauru or Manus Island, in Papua New Guinea, for offshore processing. Asylum seekers who arrived via boat on or after 19 July 2013 were all subject to offshore processing, as well as a permanent ban on settlement in Australia if found to be refugees (Karlsen & Phillips, 2014).

In December 2014, the Australian government announced a raft of further changes to the way it determines the asylum claims of people who arrived by boat between August 2012 and January 2014 - who had not yet been transferred offshore - referred to as the 'legacy caseload'. These included the re-introduction of three-year Temporary Protection Visas (TPVs), the introduction of a five-year Safe Haven Enterprise Visa (SHEV), as well as 'fast-track' processing, and limited legal assistance with restrictions or exclusions on rights of review

Since that time, depending on mode and date of arrival, there have been five main Australian asylum seeker populations, categorised according to processing arrangements: (a) community-based asylum seekers; (b) those who are held in community detention; (c) those held in onshore immigration detention (which includes centres on the Australian mainland as well as on Christmas Island, a remote island located in the Indian Ocean); (d) those who are held in offshore immigration detention on Nauru and; (e) those held in offshore immigration detention on Manus Island.

The characteristics of each of these processing arrangements varies. Community-based asylum seekers are permitted to live in the Australian community in a place of their own choosing (largely on bridging visas), however they may face a range of (frequently changing) restrictions such as no study or work rights, no access to universal healthcare, and little or no income support, whilst they await the processing of their claims (Australian Human Rights Commission [AHRC], 2014; Kaldor Centre, 2018). Asylum seekers in the onshore population may also be held in a form of detention referred to as Community Detention (CD). Asylum seekers in CD (usually unaccompanied minors, families, and other vulnerable adults) are allowed to live in the community whilst their claims for protection are being processed (known as 'residence determinations') but only in a specified location, and with certain restrictions (such no work or study rights) and other supervision arrangements (AHRC,

2014). In the onshore detention network, asylum seekers are detained in both high security immigration detention facilities (with razor wire fences, surveillance, and other prison-like features and practices), and low-security accommodation (with a more domestic environment than other forms of detention, often used for families with children). Additional places authorised to be used for onshore immigration detention include hotels, hostels, hospitals, foster care and other residential arrangements) (AHRC, 2014). The characteristics of offshore processing (outsourced to private contractors by the Australian government, and referred to as 'regional processing') on Nauru and Manus Island have garnered much attention. The offshore processing arrangements have generated controversy because of their questionable compliance with international law; many have argued that the asylum seekers should be processed in Australia, that their detention has been protracted and indefinite, and that physical conditions and access to medical assistance in the centres has been inadequate (AHRC, 2017).

Whilst a large body of evidence has accumulated over the past two decades regarding the negative impact of the asylum process on mental health, including in regards to immigration detention (Steel et al., 2006; McLoughlin & Warin, 2008; Coffey et al., 2010; Green & Eagar, 2010; Bull et al., 2012; von Werthern et al., 2018), little systematic research into self-harm across the whole Australian asylum seeker population has been conducted. In 2003, an analysis of official self-harm figures for asylum seekers in the onshore detention network, obtained by the Catholic Commission for Justice, Development and Peace (2001), estimated that self-harm rates for men and women were 12 343 and 10 227 per 100,000, respectively (Dudley, 2003). These self-harm rates were calculated as 41 and 26 times the male and female Australian national average. As these comparison figures were, however, calculated in relation to Australian community rates of suicide attempts, rather than self-harm – as

captured by the official asylum seeker figures – the limitations of these comparisons, as well as the likely imprecision of the figures, were acknowledged (Dudley, 2003).

More recently, the first systematic examination of all self-harm episodes reported to the (then-called) Department of Immigration and Citizenship (DIAC) among adult asylum seekers in the Australian onshore detention network found that 22% of asylum seekers self-harmed in the 20-month reporting period to May 2011 (Hedrick, 2017). This represented a self-harm episode rate of 224 per 1000 detained asylum seekers, and included high rates of cutting (47%), attempted hanging (19%), and head hitting (12%) (Hedrick, 2017). Since the resumption of offshore processing, however, there has been no systematic research into self-harm across the Australian asylum seeker population. It remains unknown, therefore, whether or not these trends have continued. It also remains unknown how such rates might compare to those among asylum seekers in community-based arrangements, community detention, or onshore detention.

Asylum seekers possess many of the established risk factors for self-harm (Rosenberg & Rosenberg, 2010), such as previous traumatic experiences (including torture, trafficking, and being detained), social isolation, and having contact with mental health services (often as a consequence of pre-, peri- and post-migration experiences, such as torture and trauma, and detention experiences) (von Werthern et al., 2018). In addition to this, asylum seekers have been found to have an increased vulnerability to poor mental health, with higher rates of post-traumatic stress disorder (PTSD), depression, and anxiety reported across a range of studies, compared with the general community (von Werthern et al., 2018). Furthermore, mental health has been found to deteriorate with length of immigration detention, with the chance of developing a new mental illness increasing significantly from three months (Green & Eagar, 2010). Having an insecure visa status has also been found to impact negatively on mental health, likely due to the raft of significant challenges this brings, such as protracted family

separation, housing, food, and employment insecurity (Hartley & Fleay, 2017), which in turn may increase the risk of self-harm.

The personal, social and public health burden associated with self-harm is significant, and increases with repetition (Sinclair et al., 2011). To assist the government, health services, and clinicians with planning and management, it is important to understand the epidemiology of self-harm among asylum seekers (WHO, 2014). Systematic information regarding the incidence and characteristics of self-harm across the entire Australian asylum seeker population, including the method(s) used to self-harm, and the potential influence of processing or detention arrangements, is therefore urgently needed to inform the evidence-based management and prevention of self-harm in this population.

The lack of systematic research into self-harm across the Australian asylum seeker population is largely due to the monitoring and reporting processes of the Australian government (Joint Select Committee on Australia's Immigration Detention Network, 2012; Commonwealth Immigration Ombudsman, 2013), which limit the accessibility of data. The data the government collect and store from across asylum seeker population, for example, is not regularly monitored, extracted, analysed or reported on. In 2016, the Australian government was compelled to release de-identified self-harm data for the entire asylum seeker population under the *Freedom of Information Act 1982* (Cth) for the 12 months to 31 July, 2015. As this was the largest set of self-harm data ever made publicly accessible from across the asylum seeker population – and the first since the resumption of offshore processing – the release of these data represented an invaluable opportunity to examine the incidence and characteristics of self-harm across the entire Australian asylum seeker population. This study represents an examination and analysis of these data, not previously systematically analysed or reported on by the Australian government. The aims of the present study were: (1) to examine the reported incidence of self-harm across the entire Australian asylum seeker population; (2) to

outline the method(s) used to self-harm; and (3) to establish whether episode rates and the characteristics of self-harm vary by processing arrangements, and gender.

7.3 Methods

According to the contractual arrangements the Department of Immigration and Border Protection (DIBP) have with immigration detention and community-based service providers, all self-harm incidents that occur among asylum seekers are required to be recorded on a standard incident report by detention and community-based staff and contractors. The incident reports are then sent to the DIBP where they are archived in a centralised database (Commonwealth Immigration Ombudsman, 2013). Self-harm in this context includes all forms of intentional self-injury (or self-poisoning), irrespective of motive or suicidal intent. According to the incident report matrix provided to staff and contractors released on the DIBP's Freedom of Information (FOI) disclosure log (2017), the reports are meant to include a description of the self-harming incident and method used, the location of the incident, the injury inflicted, as well as any action taken.

For the present study, all self-harm incidents recorded as occurring between 1 August 2014 and 31 July 2015 were obtained under the *Freedom of Information Act*, after being found to meet the Public Interest Test (Office of the Australian Information Commissioner Freedom of Information: conditional exceptions, 2016) and being de-identified and published on the DIBP's (2016) disclosure log. Ethics approval for this study was obtained from the University of Melbourne's Human Research Ethics Committee (#1749949.1).

Each self-harm incident was categorised according to processing arrangement, method(s) of self-harm, and gender. The incident reports available for analysis relate to episodes of self-harm, and do not include suicide. Categorisation of processing arrangement was conducted according to the details contained in each incident report. For the purposes of this study, all forms of closed onshore immigration detention (i.e., immigration detention centres,

immigration transit accommodation, immigration residential housing, and alternative places of detention (APODs) (AHRC, 2014)), were grouped together and categorised as onshore detention. Methods used to self-harm (including site of injury on body, medication, chemicals and foreign objects ingested, where provided and appropriate) were extracted from the free text in the incident reports. As no gender tick box was included on the self-harm incident reports, gender was coded following a qualitative analysis of the text in each report. Terms such as 'she', 'her', 'hers', 'female' and 'woman' and 'he', 'him', 'his', 'male' and 'man' were, for example, used to categorise gender. Cases where gender was not able to be determined were classified as a separate category of 'gender not known'. As country of origin information was not routinely recorded for each individual self-harm episode, such information could not be extracted from the self-harm incident reports. Country of origin information for each processing arrangement as a whole was instead extracted from publicly available DIBP statistics (2015), as well as those collated by the Refugee Council of Australia (2015). An independent coder was used to assess the way a sub-sample of 100 incident reports were categorised, as a reliability check. The inter-rater reliability was found to be very high (kappa = 0.95) (McHugh, 2012).

Data were analysed using SPSS version 24. Chi-square tests were used to establish differences between proportions, where cell counts permitted. The annual episode rate of self-harm per 1000 was calculated for each asylum seeker population according to processing arrangement using the average adult population figures for the 12-month period, according to the DIBP's (2015) statistics (Table 7.1), with 95% confidence intervals based on Poisson distribution.

Table 7.1

Average number of adults in the Australian asylum seeker population for the 12 months to 31 July 2015, by processing arrangements and gender

	Male population	**Female population**	**Total population**
Community-based	21,136	2,758	23,894
Community detention	621	563	1,184
Onshore detention	1,815	361	2,176
Nauru	563	159	722
Manus Island*	1,005	-	1,005

*Manus Island houses only male asylum seekers

7.4 Results

Study sample

According to the DIBP's (2015) immigration detention and community statistics, as at 31 July 2015, the top two nationalities of asylum seekers in onshore detention and community detention were Iran and Sri Lanka. Similarly, official Department of Home Affairs (previously DIBP) (2015) onshore processing statistics as at 31 June 2015 (the closest reporting period available) indicate that the top two nationalities of community-based asylum seekers were Sri Lanka and Iran. Figures collated by the Refugee Council of Australia (2015) relating to offshore processing show that the largest number of asylum seekers transferred to Nauru and Manus Island were from Iran, the second largest group were stateless. Significant numbers were also from Sri Lanka, Afghanistan, Pakistan and Iraq. During the 12-month study period, 1 August 2014 to 31 of July 2015, there were 949 episodes of self-harm recorded as occurring across the Australian asylum seeker population. Table 7.2 outlines the descriptive statistics for self-harm episodes, including by processing arrangements and gender.

Table 7.2

The number and percentage of self-harm episodes in the Australian asylum seeker population in the 12 months to 31 July 2015, by processing arrangements and gender

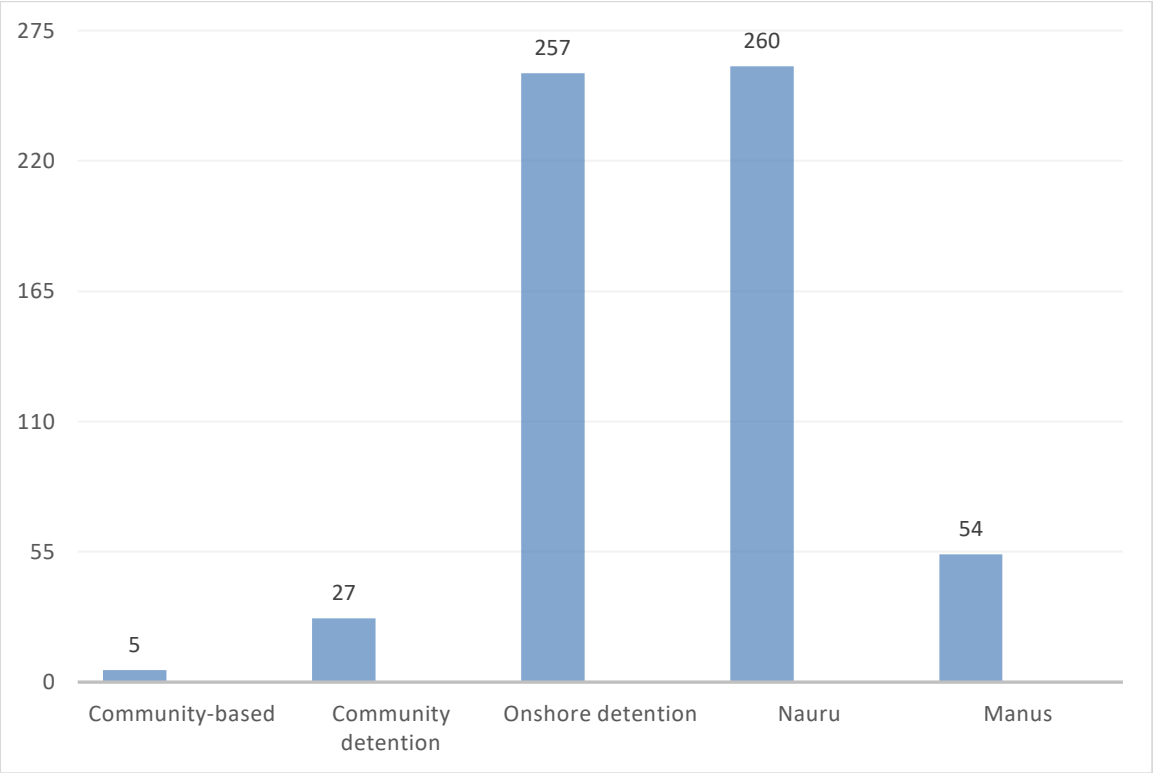
Processing arrangements	**Males**	**Females**	**Gender not known**	**Total**
	n=426	**n=164**	**n=359**	***N*=949**
Community-based	32 (7.5%)	8 (4.9%)	73 (20.3%)	113 (11.9%)
Community detention	8 (1.9%)	8 (4.9%)	17 (4.7%)	33 (3.5%)
Onshore detention	231 (54.2%)	90 (54.8%)	239 (66.6%)	560 (59.0%)
Nauru	100 (23.5%)	58 (35.4%)	30 (8.4%)	188 (19.8%)
Manus Island	55 (12.9%)	-	-	55 (5.8%)

Values are presented as number (%).

Episode rates of self-harm by processing arrangements

The total (combined male and female) self-harm episode rates per 1000 (95% CI) for asylum seekers in the Australian asylum seeker population in the 12 months to 31 July 2015 were: community-based, 5 (95% CI 1-9); community detention, 27 (95% CI 17-36); onshore detention, 257 (95% CI 225-288); Nauru, 260 (95% CI 228-291); Manus Island, 54 (95% CI 40-68) (see Figure 7.1).

Figure 7.1. Self-harm episode rates per 1000 asylum seekers, for the Australian asylum seeker population in the 12 months to 31 July 2015, by processing arrangements.



Self-harm by gender, and processing arrangements

Information relating to gender could be extracted from 590 (62.1%) of the self-harm incident reports. In relation to the total sample, the analysis found that males were involved in 426 (72.2%) of all self-harm episodes where gender was known, and females in 164 (27.8%) (Table 7.2). There were no significant differences in self-harm episodes between male and female asylum seekers in onshore detention (χ^2 (1, N = 590) = .020, p =.887) or community-based arrangements (χ^2 (1, N = 590) = 1.30, p =.254), in incidents where gender was known, however female asylum seekers in Nauru were significantly more likely to self-harm than male asylum seekers in Nauru (χ^2 (1, N = 590) = 8.54, p =.003). Manus Island houses only male asylum seekers, so only males were involved in self-harm episodes in that particular population. Cell counts were too low to detect significant gendered differences in self-harm among asylum seekers in community detention.

Methods of self-harm by gender

As outlined above, there were 949 episodes of self-harm recorded as occurring in the Australian asylum seeker population in the 12 months to 31 July, 2015, including 175 episodes (18.4%) where the method was not recorded. The analysis of episodes of self-harm with known methods indicated that eleven different types of methods were used by the Australian asylum seeker population during the study period.

Details regarding gender were able to be extracted from 552 (71.3%) of the 774 incident reports with known methods of self-harm. Males were involved in 404 (52.2%) episodes with known methods, and women in 148 (19.1%). Gender was not able to be identified in 222 episodes (28.7%) with a known method of self-harm. The most common methods of self-harm for both males and females were: cutting (37.4%), self-battery (26.0%), and attempted hanging (11.0%). There were no significant gender differences in the three most common methods of self-harm, in incidents where gender was known (χ^2 (2, N = 442) = 4.56, p = .102). Table 7.3 outlines the descriptive statistics for methods of self-harm, including by gender.

Table 7.3

Methods of self-harm used by the Australian asylum seeker population in the 12 months to 31 July 2015, including by gender

Methods of self-harm	**Male**	**Female**	**Gender not known**	**Total**
	n=404	**n=148**	**n=222**	***N*=774**
Cutting	152 (37.6%)	64 (43.2%)	74 (33.3%)	290 (37.4%)
Self-battery*	126 (31.1%)	32 (21.6%)	41 (18.4%)	199 (26.0%)
Hanging	48 (12.0%)	20 (14.0%)	15 (7.0%)	83 (11.0%)
Self-poisoning by medication	16 (4.0%)	13 (8.7%)	50 (22.6%)	79 (10.0%)
Self-poisoning by chemicals	18 (4.4%)	9 (6.0%)	30 (13.5%)	57 (7.3%)
Ingesting foreign object	20 (5.0%)	1 (0.6%)	7 (3.1%)	28 (3.6%)
Burning	14 (3.5%)	7 (4.7%)	-	21 (2.7%)
Lip sewing	8 (2.0%)	-	1 (0.4%)	9 (1.1%)
Jumping off high structures	2 (0.4%)	1 (0.6%)	3 (1.3%)	6 (0.7%)
Voluntary starvation**	-	-	1 (0.4%)	1 (0.1%)
Drowning	-	1 (0.6%)	-	1 (0.1%)

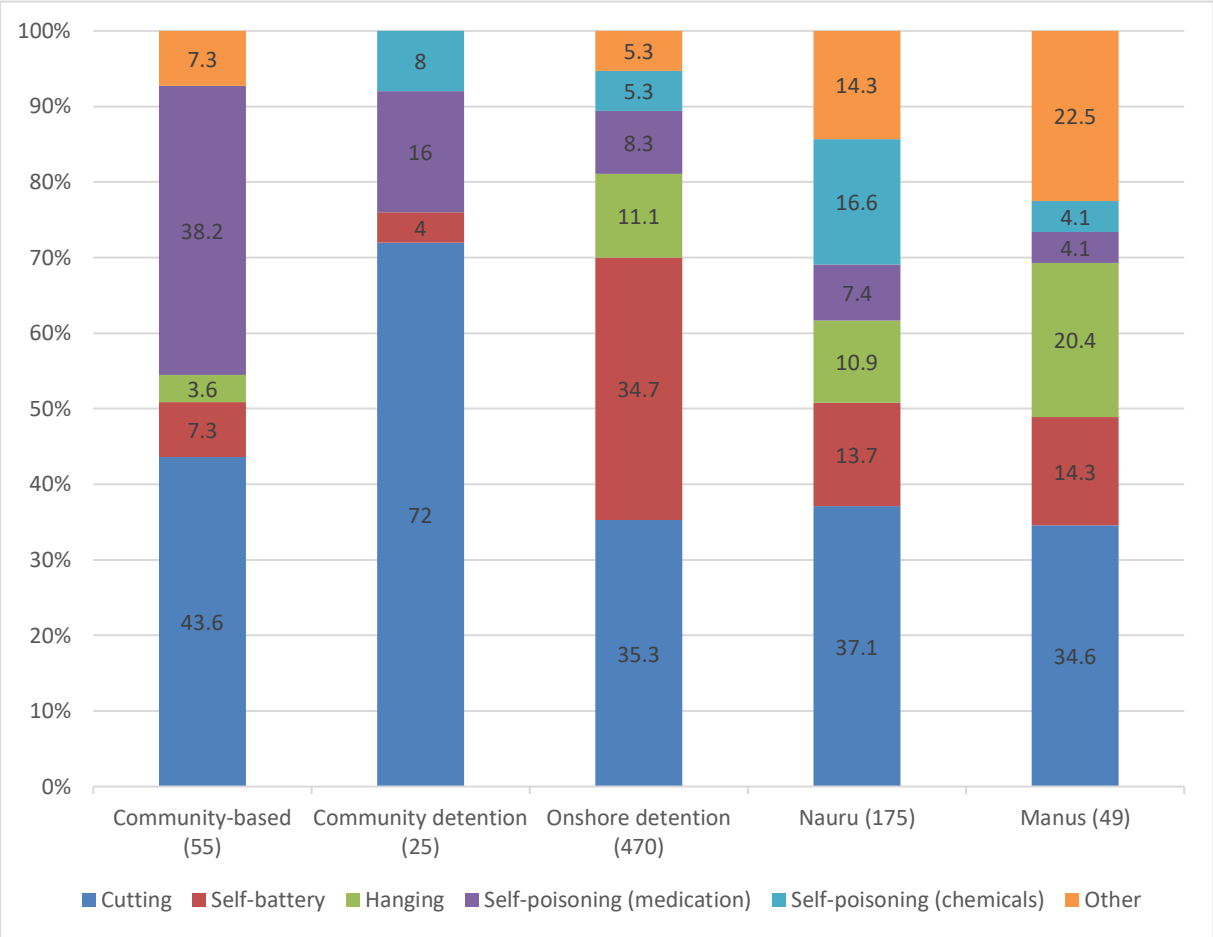
*Self-battery is defined as striking or beating oneself heavily and repeatedly in order to cause injury. It may also involve striking one's body against hard objects, such as walls, floors or other heavy, immovable objects. **Voluntary starvation is usually recorded under another category of notifiable incidents, which likely accounts for the single incident reported as self-harm here. Values are presented as number (%).

Methods of self-harm by processing arrangements

Figure 7.2 outlines the methods of self-harm used by the Australian asylum seeker population, including by processing arrangements (i.e., community-based, community detention, onshore detention, offshore (Nauru), and offshore (Manus)). Of the 774 episodes with known methods, 290 episodes (37.4%) involved cutting (community-based: 43.6%; community detention: 72.0%; Onshore: 35.3%; Nauru: 37.1%; Manus: 34.6%), 199 episodes (26.0%) involved self-battery (community-based: 7.3%; community detention: 4.0%; Onshore: 34.7%; Nauru: 13.7%; Manus: 14.3%), and 83 episodes (11.0%) attempted hanging (community-based: 3.6%; Onshore: 11.1%; Nauru: 10.9%; Manus: 20.4%).

The three most common methods of self-harm varied by held detention (Onshore, Nauru, and Manus) and community-based processing arrangements: asylum seekers in held detention, compared with the two types of community-based processing arrangements, were significantly more likely to self-harm by self-battery (37.1% vs 10.2%) and attempted hanging (15.5% vs 4.1%) (χ^2 (2, N = 572) = 26.28, p < .001). Asylum seekers in community-based arrangements (χ^2 (2, N = 572) = 10.89, p =.004), and community detention (χ^2 (2, N = 572) = 15.29, p < .001), were significantly more likely to self-harm by cutting than those in all other processing arrangements.

Figure 7.2. Methods of self-harm used by the Australian asylum seeker population in the 12 months to 31 July 2015, according to processing arrangements.



Site of injury

The site of injury on body was able to be extracted from 542 (70.0%) of the 774 self-harm episodes where method was known (excluding episodes of self-poisoning by medication, chemicals, as well as by ingesting foreign objects, voluntary starvation, and drowning). The head was the most common site of injury (194 episodes, 36.0%), followed by the arm and wrist (191 episodes, 35.2%), the neck (78 episodes, 14.3%), hand and fingers (40 episodes, 7.4%), the chest and upper torso (12 episodes, 2.2%), the stomach (10 episodes, 1.8%), the leg (10 episodes, 1.8%), and the lower body (7 episodes, 1.3%).

Types of medication used for self-poisoning

Of the 79 episodes of self-poisoning by medication, there were 45 episodes (56.9%) where the type of medication was not recorded. Given the small numbers, and the high proportion of episodes of self-poisoning where medication type was not known, results are presented for the total population, rather than by processing arrangements. Of the 34 episodes with known medication, 10 (29.4%) involved prescription medication (not otherwise stated), 7 episodes (20.5%) a combination of prescription (not otherwise stated) and over the counter medication (not otherwise stated), 4 episodes (11.7%) sleeping tablets, 4 episodes (11.7%) anti-depressants, 4 episodes (11.7%) paracetamol, 3 episodes (9.0%) over the counter medication (not otherwise specified), 1 episode (3.0%) anti-angina medication, and 1 episode (3.0%) antibiotics.

Types of chemicals used for self-poisoning, by processing arrangements

There were 57 episodes of self-poisoning by chemicals, with the chemical type recorded in all episodes. Of the 57 episodes, 20 (35.0%) involved insect repellent (called Rid) (Onshore: 8.0%; Nauru: 62.0%), 16 episodes (28.0%) washing powder (Onshore: 40.0%; Nauru: 17.2%; Manus: 100%), 13 episodes (23.0%) shampoo (Onshore: 36.0%; Nauru: 14.0%), 4 episodes (7.0%) cleaning products (Onshore: 16.0%), 2 episodes (3.6%) alcohol (Nauru: 3.4%; community-based: 100%), 1 episode (1.7%) lice treatment (community detention: 100%), and 1 (1.7%) Milton sterilising tablets (Nauru: 3.4%).

Types of foreign objects ingested, by processing arrangements

There were 28 episodes of self-harm involving the ingestion of foreign objects, including one episode where the type of foreign object was not recorded. Of the 27 episodes where the foreign object type was known, 15 (55.6%) involved swallowing razor blades (Onshore: 8 episodes; Manus: 4 episodes; Nauru: 3 episodes), 3 episodes (11.1%) swallowing pieces of

metal (Manus: 1 episode; Onshore: 1 episode; Nauru: 1 episode), 2 episodes (7.4%) swallowing rocks (Nauru: 2 episodes), 2 episodes (7.4%) swallowing metal screws (Nauru: 2 episodes), 2 episodes (7.4%) swallowing nail clippers (Manus: 2 episodes), 1 episode (3.7%) swallowing a plastic medication cup (Nauru: 1 episode), 1 episode (3.7%) swallowing tea bags (Nauru: 1 episode), and 1 episode (3.7%) swallowing a blood sugar testing strip (Onshore: 1 episode).

7.5 Discussion

This study was the first to examine the incidence and characteristics of self-harm across the entire Australian asylum seeker population, including by processing arrangements. Between 1 August 2014 and 31 July 2015, 949 self-harm incidents were reported to have occurred across the Australian asylum seeker population. As highlighted elsewhere (Joint Select Committee on Australia's Immigration Detention Network, 2012; Commonwealth Immigration Ombudsman, 2013; Australian National Audit Office [ANAO], 2017; Legal and Constitutional Affairs Reference Committee, 2017), it is likely that self-harm incidents among the Australian asylum seeker population are under-reported. For community-based asylum seekers, as well as those in community detention, contact with DIBP-appointed case managers or contractors can be limited (Refugee Council of Australia, 2018), meaning that self-harm incidents may instead be identified and managed by general practitioners in the community and/or emergency departments and thus not reported to the DIBP. Differing levels of support from non-government organisations (NGOs) and service providers on Nauru and Manus Island, as well as the timing of the roll-out and use of the new centralised data base for recording incidents (known as the Planning and Operational Management System (POMS)) during this period, may have also contributed to inconsistent reporting and recording of incidents for these populations (ANAO, 2017). Furthermore, recent research has highlighted the methodological limitations of using only one data source to identify self-

harm, including among incarcerated adults (Borschmann et al., 2011; Borschmann et al., 2017). The self-harm figures for the Australian asylum seeker population recorded here, based on the incidents reported to the DIBP in the 12 months to 31 July 2015, are likely to reflect an under-ascertainment of the true number of incidents. The rates we have calculated are likely an under-estimate of the true incidence of self-harm in this population.

Rates of self-harm

Self-harm episode rates were highest among asylum seekers in offshore detention (Nauru, 260 per 1000, Manus, 54) and onshore detention (257), and lowest among asylum seekers in community-based arrangements (5) and community detention (27). Calculated rates of self-harm among asylum seekers in Nauru (followed closely by rates in onshore detention) – the highest episode rates identified in the present study – were therefore 52 times higher than the lowest recorded self-harm episode rates; those among community-based asylum seekers. To put these rates in context, the overall incidence of hospital-treated self-harm events (not individuals) in the Australian community during 2012-13 was 1.2 per 1000 (Pointer, 2015). This means that self-harm episode rates among asylum seekers in offshore detention in Manus and Nauru were 45 and 216 times the Australian community rates for hospital-treated self-harm, respectively. Furthermore, rates among asylum seekers in onshore detention were 214 times the community rates for hospital-treated self-harm, whilst rates among asylum seekers in community detention were 22 times these community rates. By comparison, self-harm episode rates among asylum seekers in community-based arrangements were four times the Australian community rates for hospital-treated self-harm. Our findings highlight the extraordinarily high rates of self-harm among detained asylum seekers compared to rates observed in the general Australian population, and among asylum seekers in community-based settings. This almost certainly reflects the deleterious effects of immigration detention, and warrants urgent investigation.

The higher rates of self-harm found in asylum seekers detained in offshore detention on Nauru compared with those held on Manus Island could reflect the fact that Nauru had an NGO operating on the island and providing welfare services for some of this period, whereas Manus did not (ANAO, 2017). This means that there were more staff on Nauru at this time, particularly those operating from a welfare perspective, able to detect (and report) episodes of self-harm. Difficulties and delays in recruiting and retaining staff to work on Manus were also reported at this time (ANAO, 2017). In addition to this – as further highlighted by the Australian National Audit Office's (2017) performance audit of garrison support and welfare services in Manus and Nauru - the record keeping and data management processes used by those in a position to detect and report self-harm (and other) incidents, was found to contribute to the under-reporting of incidents during the study period, as well as the inconsistency in incident reporting identified across service providers in Nauru and Manus. A greater range of services, with higher levels of staffing, offered in the onshore detention network may also account for some of the differences in rates of self-harm identified in asylum seekers there, compared with on Manus. A report into the incident reporting (largely from a Work, Health and Safety perspective) in Australian immigration detention during the same period offers further corroborating evidence for this: the level of under-reporting of notifiable incidents (including self-harm) on Manus was found to be highly likely (Australian Lawyer's Alliance, 2016).

The higher rates of self-harm still found among community-based asylum seekers in the current study compared to Australian community rates could reflect the pre-migration trauma and flight histories of the asylum seekers, as well as an increased vulnerability to poor mental health (Robjant et al., 2009). This includes, for example, having experienced torture and trauma, and an elevated risk of developing PTSD, depression, and anxiety, compared with the general community or host country (von Werthern et al., 2018). As many permanent residents

with similar histories go on to enjoy good psychological health (Coffey, 2011), however, this explanation cannot fully account for these higher rates. The findings might instead, then, point to the restrictive conditions and characteristics associated specifically with community-based processing – already known to cause mental distress among asylum seekers - such as denial of work rights (only granted to many community-based asylum seekers in December, 2014), limited or no welfare assistance, difficulties finding and securing appropriate accommodation, inconsistent access to healthcare, and no study rights, amongst others (Correa-Vellez et al., 2008; Hartley & Fleay, 2017; Hartley et al., 2018). They might also speak to other – largely modifiable - factors shared more broadly across all processing arrangements, such as family separation, length of claim processing times, and access to adequate legal support, previously found to precipitate self-harm episodes among asylum seekers in Australia (Hedrick, 2017). In addition to this, the findings may point to the previous experiences of detention that the asylum seekers may have had prior to being released into the community for processing, as research indicates that the impact of detention may be enduring (Coffey et al., 2010). These government policies and practices need to be urgently re-evaluated. The limitations of the comparisons between hospital-treated self-harm and the types of self-harm presented in the current study - which may or may not have involved hospitalisation - are acknowledged. Episode rates of self-harm from the Australian prison population, which may have provided better comparison data, were not available. The limitations in potential comparisons between self-harm in prisoners and asylum seekers are also acknowledged – seeking asylum is not a crime, it is a human right, and yet many asylum seekers are treated similarly to prisoners, with serious consequences to their mental health.

Methods of self-harm

Cutting was the most common method of self-harm across the entire Australian asylum seeker population, in episodes with known methods, followed by self-battery, and attempted

hanging; the three most common sites of injury on the body were the head, the arm and wrist, and the neck. The three most commonly reported methods of self-harm amongst males and females, in episodes where gender was known, were the same. The most frequently reported methods of self-harm found in the present study for the whole population were closely aligned with those identified in the previously mentioned study (Hedrick, 2017) into self-harm among asylum seekers in the onshore detention network. This indicates both a continuing trend in methods used by asylum seekers in the onshore detention population, as well as some consistency in the use of methods across the Australian asylum seeker population. Whilst high rates of hanging were identified in the earlier study, the small number of females identified in that study made meaningful comparisons between male and female rates difficult to make. The trend in high rates of attempted hanging now clearly identified for both males and females differs from those in the general Australian community (Pointer, 2015), and is of concern.

This pattern of findings contrasts with what has been previously established about gendered dimensions to self-harm – that whilst women may be over-represented in self-harm incidents, males are more likely to choose more violent (and potentially lethal) methods of self-harm than women (Canner et al., 2016). A possible explanation for these high rates of hanging among both genders might relate to the cultural backgrounds of those in the Australian asylum seeker population during the study period. Research does highlight that gendered differences in self-harm may vary according to country of origin (Goosen et al., 2011; Sundvall et al., 2015). As details regarding country of origin were not recorded in the individual self-harm incident reports – country of origin information was only available for each processing arrangement as a whole - it was not possible to establish whether self-harm methods varied according to cultural background and gender. Further research, as well as

improved self-harm data monitoring and collection processes, are needed to better understand the cultural and gendered dimensions to self-harm among asylum seekers.

Methods of self-harm by processing arrangements

Asylum seekers in held detention were found to use a greater variety of self-harm methods (an average of 9), in incidents with known methods, compared with asylum seekers in community-based arrangements and community detention, who were using on average just over half the number of methods (5). Concerningly, rates of attempted hanging were significantly higher among asylum seekers in held detention, compared with those in community-based settings. As hanging is strongly associated with an increased risk of suicide (Runeson et al., 2010), these findings highlight the urgent need for the use of held immigration detention to be re-evaluated.

Whilst asylum seekers in community-based arrangements and community detention used a range of more traditional methods (for example cutting, self-poisoning by medication, and self-battery), asylum seekers in held detention used both traditional methods, coupled with other less common methods. These included, for example, self-poisoning by chemicals, largely involving insect repellent (35.0%) (90% of these episodes occurred among asylum seekers on Nauru), as well as ingesting foreign objects, largely involving swallowing razor blades (55.5%), metal (11.1%), and rocks (7.4%) (whilst numbers were very small, 100% of episodes involving swallowing rocks occurred on Nauru).

This is consistent with evidence that individuals in detained populations often improvise in their choice of self-harm methods and devices - perhaps as more common or traditional means become no longer accessible to them - and that these means often relate to the environment or setting in which they are housed (Tartaro & Lester, 2010; D'arcy, 2017). These findings further highlight the increased risk of self-harm for asylum seekers in held

detention compared with those in community-based arrangements and community detention. They also highlight the urgent need for a more upstream approach to self-harm prevention among asylum seekers in held detention, such as community-based processing – in the Australian community - to be implemented. Indeed, based on the study's findings, the most informed and reasonable self-harm prevention strategy is to introduce community-based processing for all asylum seekers. Clearly, such an approach would need to address the characteristics associated with community-based processing, previously established to cause psychological distress among asylum seekers, and to precipitate episodes of self-harm, as highlighted above.

It must be noted that since these data were found to meet the Public Interest Test and released under FOI laws in 2016, there has been no official release of more recent or detailed data regarding self-harm across the entire Australian asylum seeker population. There has also been no systematic monitoring of self-harm among asylum seekers (including by gender, age, country of origin, method(s) used to self-harm, precipitating factors, processing arrangements, or held detention type) by the Australian government over this three-year period, in order to better understand and prevent self-harm among this population. Asylum seekers have now been held in offshore immigration detention on Nauru and Manus Island for six years. Given the rates of self-harm found among the Australian asylum seeker population in the current study, including rates in Nauru and onshore immigration detention that are more than 200 times the Australian community hospital-treated rates, it is clear that the health of asylum seekers remains at risk without urgent changes to government policy regarding mandatory immigration detention.

Limitations

There were a number of limitations to our study. Firstly, the number of unreported self-harm incidents across the Australian asylum seeker population is unknown, meaning that the rates

reported here should be considered conservative figures at best. Secondly, as some of the data we sought to extract from the self-harm incident reports were not routinely reported, or required to be reported by the DIBP, the amount of data we were able to collect was limited. Thirdly, and in a similar vein, information relating to gender was only able to be extracted from approximately two-thirds of the incident reports. Some asylum seeker populations, therefore, had higher proportions of missing data pertaining to gender, than other populations, limiting our ability to calculate reliable male and female self-harm rates. Fourthly, whilst country of origin information was available from the DIBP for each processing arrangement as a whole, the individual self-harm incident reports did not contain such information. This limited our ability to establish whether self-harm rates and method(s) used to self-harm varied according to country of origin and/or cultural background, and gender. Lastly, in some instances, cell sizes limited our ability to detect statistically significance differences.

7.6 Conclusions

Self-harm episodes among the Australian asylum seeker population, particularly for asylum seekers detained in offshore and onshore detention, were found to occur at exceptionally high rates compared with those in the wider Australian community. Our analysis of the Australian government's own self-harm data provides evidence of the lowered self-harm risk for both asylum seekers living in community-based arrangements and community detention, compared to held detention. These findings clearly illuminate the deleterious impact of immigration detention on the health of detained asylum seekers; the extremely high self-harm rates identified in the present study are cause for considerable concern and warrant urgent attention. Furthermore, as self-harm is often reflective of broader mental health concerns, it is highly likely that there are significant, additional negative mental health consequences of immigration detention for the Australian asylum seeker population, although the present study cannot directly account for these. Our findings also demonstrate that rates of self-harm

among community-based asylum seekers are closer to hospital-treated self-harm rates in the wider Australian community, compared to the very high levels of self-harm in detention settings. Based on our findings, then, the most informed course of action would be to swiftly introduce community-based processing (in the Australian community), to address the largely modifiable precipitants of distress and self-harm associated with these arrangements, and to institute the independent monitoring and reporting of self-harm among asylum seekers.

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Chapter 7: Part two - Self-harm among asylum seekers in Australian immigration detention

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7.8 Commentary

Self-harm among asylum seekers in Australian immigration detention has attracted much attention over the past two decades. In 2012, the Australian government reinstated offshore processing for asylum seekers – a policy previously maintained from 2001-2008 – meaning that asylum seekers who arrived by boat were transferred to Manus Island in Papua New Guinea, or the Pacific island nation of Nauru, for processing.[1] National and international attention regarding perceived rates of self-harm in the Australian asylum seeker population has intensified since this time,[2,3] as have calls for self-harm prevention strategies to be implemented.[2]

A large body of evidence, including from a 2018 systematic review,[3] indicates that asylum seekers have a higher prevalence of depression, anxiety and post-traumatic stress disorder, compared with the general community. Evidence also suggests that asylum seekers possess many of the risk factors associated with self-harm,[3] such as previous traumatic experiences, mental health problems (often resulting from pre-and post-migration experiences, including torture and trauma), and social isolation, with detention known to exacerbate such risk.[4] Additionally, mental health has been shown to deteriorate with length of detention.[3,5] Despite evidence of the increased risk to the mental health of asylum seekers, Australia, as well as many other high-income countries, continues to detain asylum seekers.[1] Yet little is known regarding the rates and characteristics of self-harm among asylum seekers, largely because accessible data are absent.

We investigated self-harm among people seeking asylum in Australia (including those transferred to Nauru and Manus Island) over a 12-month period. Calculated episode rates of self-harm in immigration detention were more than 200 times higher than rates of hospital-treated self-harm in the general Australian population.[6] By contrast, episode rates of self-

harm among community-based asylum seekers were four times higher than rates of hospital-treated self-harm in the general Australian population.[6]

Our analysis of the Australian government's own self-harm data[6] provides evidence of the lowered self-harm risk for asylum seekers in community-based arrangements and community detention, compared with people in immigration detention. Our findings point clearly to the deleterious effect of immigration detention on the health of asylum seekers. The high episode rates of self-harm identified in our study[6] constitute a public health crisis and warrant urgent attention.

Responses to this public health issue are poor. Independent and systematic monitoring of self-harm among people seeking asylum in Australia is needed to identify trends and to implement prevention strategies, but is not being done. In light of the episode rates of self-harm, the health of asylum seekers will remain at risk without changes to government policy regarding detention.

An informed government response would include three essential aspects: only using detention as an absolute last resort for the shortest possible time; mental health services specifically tailored to meet the needs of asylum seekers; and the independent monitoring of self-harm in line with WHO self-harm reporting guidelines.[7] Without such a response, a reduction in the high rates of self-harm observed among asylum seekers is unlikely to occur.

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Chapter 8: Self-harm among asylum seekers in Australian onshore immigration detention: How incidence rates vary by held detention type

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8.1 Abstract

Background: Detained asylum seekers are at increased risk of self-harm, and the type of detention in which they are held may further exacerbate this risk. In Australia, there are four types of closed (or held) immigration detention for people seeking asylum, with varying levels of security and supports: Immigration Detention Centres [IDCs], Immigration Transit Accommodation [ITAs], Immigration Residential Housing [IRH], and Alternative Places of Detention [APODs]. The objective of this study was to examine the variation in the incidence and method(s) of self-harm among asylum seekers in Australian onshore immigration detention, according to the type of detention in which they are held.

*Methods***:** We obtained data on all self-harm incidents reported among asylum seekers in Australian onshore immigration detention according to held detention type, as well as individual facility, between 1 August 2014 and 31 July 2015, by Freedom of Information. We calculated self-harm episode rates per 1000 asylum seekers using the average population figures for held detention type, as well as for each individual facility comprising the main types of held detention. Method(s) used to self-harm was also extracted for the main sub-populations.

Results: The study included 560 episodes of self-harm. Individual facility rates of self-harm ranged from 91 per 1000 asylum seekers (95% CI 72-110) in Yongah Hill IDC to 533 per 1000 asylum seekers (95% CI 487-578) in Perth IDC. On average, calculated self-harm episode rates were highest among asylum seekers in: Immigration Transit Accommodation facilities, 452/1000 (95% CI 410-493); Alternative Places of Detention, 265/1000 (95% CI 233-296); and Immigration Detention Centres, 225/1000 (95% CI 195-254). The most frequently reported methods of self-harm across the main types of held detention were: cutting (35.2%), self-battery (34.8%), and attempted hanging (11.1%).

*Conclusions***:** Self-harm rates for asylum seekers in all types of closed immigration detention were many times higher than rates found in the general population. Average rates were not lower in facilities with lower security features.

Keywords

Self-harm; Asylum seekers; Immigration detention; Australia; Mental health

8.2 Background

In response to recent surges in migration, many countries around the world apply various forms of administrative detention to asylum seekers who arrive on their territories [1]. In Australia, mandatory immigration detention - both onshore and offshore, as dictated by government policy - has been applied to all 'unlawful non-citizens' for over 25 years [2]. During periods where there were a large number of asylum seekers arriving by boat, the vast majority of the detained population were asylum seekers [1]. Australia's offshore immigration detention facilities housed on the Pacific island nation of Nauru and Manus Island, in Papua New Guinea, have attracted a great deal of attention [3], particularly regarding detention conditions and remoteness of location, and the impact these factors may have on asylum seekers' physical and mental health. Immigration detention environments in Australia are also diverse - until recently there were 15 operational individual detention facilities in the onshore detention network (subsequent to the period examined in this study, a number of facilities have closed). Each facility may present its own challenges for asylum seekers.

There are four main types of held immigration detention (comprised of the aforementioned individual detention facilities) in the Australian onshore detention network (which includes Christmas Island): (a) Immigration Detention Centres (IDCs); (b) Immigration Transit Accommodation (ITAs); (c) Immigration Residential Housing (IRH), and; (d) Alternative

Places of Detention (APODs) [4]. IDCs have the highest security arrangements in the Australian onshore detention network, with high security fencing, guards, and additional forms of surveillance [4]. IDCs are used to detain asylum seekers, individuals who overstay their visas, and individuals who have had their visas cancelled or refused for character reasons [4]. ITAs are closed detention centres that may have less stringent security measures than IDCs [4]. They were initially designed to house individuals who were being transferred to other detention facilities, or who were being removed (otherwise known as being deported) [4]. IRH is classified as a secure form of detention, with lower security features than IDCs [4]. IRH provides accommodation that can cater to families, although they may also be used to house single adults. APODs are places designated by the (then-called) Department of Immigration and Border Protection [DIBP] to be used for detaining asylum seekers who are assessed as posing minimal risk to the Australian community [4]. APODs are less secure than other types of held detention, and often have a more domestic environment (generally for housing children and families) to provide individuals with more privacy and the opportunity to do things together, such as cook and eat [5].

It is now well established that immigration detention has a deleterious impact on the psychological well-being of many asylum seekers [6-8], and that these adverse effects may be enduring [9]. Until recently, however, little research regarding self-harm in the Australian asylum seeker population existed. A 2017 study of self-harm among asylum seekers in onshore immigration detention reported a self-harm episode rate of 224 per 1000 detained asylum seekers in the 20-month period to May 2011 [10]. Our more recent research into self-harm across the whole Australian asylum seeker population between 1 August 2014 and 31 July 2015 [11] reported a self-harm episode rate of 257 per 1000 detained asylum seekers in onshore immigration detention, representing a 15% increase in self-harm rates since May 2011. This self-harm episode rate was also calculated to be 214 times the Australian

community rate for hospital-treated self-harm during the same period [11]. For further comparison, our calculated self-harm episode rates among community-based asylum seekers (5 episodes/1000 asylum seekers), and those held in community detention (27 episodes/1000 asylum seekers) were 4 and 22 times the Australian community rates for hospital-treated self-harm, respectively [11]. Such findings are consistent with research highlighting that asylum seekers are at increased risk of self-harm [12], and that being detained further exacerbates this risk [13-14].

The findings from our earlier study convey important information about the elevated risk of self-harm among asylum seekers in the onshore immigration detention population as a whole, in comparison with both asylum seekers in community-based arrangements and community detention [11], as well as the general Australian population. They do not, however, provide any insight into the influence different types of held detention might have on the incidence of self-harm among asylum seekers. Nor do they permit scrutiny of self-harm rates among asylum seekers at the individual detention facility level. In this way, the unique influence that different types of held detention might have on rates of self-harm have thus far been obscured, by treating the entire onshore detention network as one homogenous environment. As such information may assist in the prevention of self-harm among detained asylum seekers, it warrants urgent attention. Indeed, research from the prison literature has found that detention type or setting impacts on self-harm risk among incarcerated adults [14]. Specifically, self-harm risk has been found to be associated with higher security detention facilities (particularly for men) [14], transit or remand centres [14-15] (where transfers to or from settings may occur more frequently), and mixed detention facilities (particularly for women) [14]. Asylum seekers in the Australian onshore detention population are housed in both high and low security centres, as well as in different types of transit and mixed accommodation; these detention environments may differentially impact on self-harm risk.

The aim of the current study was therefore to build and extend upon our earlier research into self-harm in the onshore immigration detention population as a whole, by examining the variance in the incidence and method(s) of self-harm among asylum seekers in onshore immigration detention according to held detention type, and each individual facility comprising each type. Whilst the vast majority of 'unlawful non-citizens' detained in onshore immigration detention during the study period were asylum seekers, referred to as 'irregular maritime arrivals' (IMAs) (accounting for at least 70% of the entire population – the average annual composition of the population was 70% IMAs, 2.4% air arrivals, 12.2% visa cancellations, 17.3% overstayers, 0.1% seaport arrivals, and 0.02% illegal foreign fishers [16]) - there was a remaining group who were detained for various other reasons, some of whom were also asylum seekers (e.g., some visa cancellations will also have been asylum seekers). Given the composition of onshore immigration detention during this time, and for the sake of brevity, we will refer to the overall population in this study as asylum seekers in Australian onshore immigration detention.

8.3 Methods

We obtained data on all self-harm incidents reported among asylum seekers in Australian onshore immigration detention between 1 August 2014 and 31 July 2015, by Freedom of Information [FOI] [17]. These data were published on the Department of Immigration's FOI disclosure log [18]. Ethics approval for this study was obtained from the University of Melbourne's Human Research Ethics Committee (#1749949.1).

We undertook a content analysis study of all self-harm incidents, with self-harm defined as all forms of intentional self-injury (or self-poisoning), irrespective of suicidal intent or motivation [11, 19]. Parts of this methodology have been described extensively elsewhere [see 11]. For this study, information regarding held detention type, and individual facility were extracted from the details provided in each incident report. Whilst community detention

is classified as a type of held immigration detention [4], it was not included in this study as we have previously examined the incidence of self-harm in this population elsewhere [11]. Details relating to age and country of origin were not able to be extracted from the incident reports. This potentially identifying information, if noted, would have been redacted prior to the incidents being released via Freedom of Information. Details regarding country of origin relating to the whole onshore immigration detention population were instead sourced from official DIBP [16] statistics. As the Department of Immigration does not publish country of origin information for each type of detention, or at the individual facility level, we were not able to report such details. The incident reports available for analysis did not include suicide. (The most definitive source of deaths among Australian asylum seekers, the Australian Border Deaths Database [20], reports that there were three suicides by asylum seekers during the study period. All three deaths occurred among asylum seekers living in the Australian community). One self-harm episode was reported as occurring in Curtin IDC, however as the official population figures [16] for this facility were recorded as zero for the entire 12-month period (with those held at the detention centre transferred to other facilities at the beginning of the study period, and the centre closing sometime after this), this incident was not included in the analysis. Ten percent of the incident reports were double-coded by an independent coder. Inter-rater reliability was established to be high (kappa = 0.95), and based on this, all remaining incidents were coded by a single coder (KH) [21].

We calculated the episode rate of self-harm per 1000 detained asylum seekers for each held detention type, using the average adult population figures [16] (with 95% Confidence Intervals [CI]). Self-harm episode rates were also calculated for each individual facility comprising each held detention type, where population figures were provided by the DIBP. Numbers were too low to calculate episode rates for IRHs.

8.4 Results

Demographics

Between 1 August 2014 and 31 July 2015, there were a total of 560 self-harm episodes among asylum seekers in Australian onshore immigration detention (231 episodes (41.2%) by males, 90 (16.0%) by females, and 239 episodes (42.6%) where gender could not be determined) (see Table 8.1). According to official statistics [16], the two major source countries of asylum seekers detained in Australian onshore immigration detention were Iran and Sri Lanka. One in five (19.6%) asylum seekers held in onshore detention had been detained for greater than 2 years.

Table 8.1

The number of self-harm episodes among asylum seekers in Australian onshore immigration detention between 1 August 2014 and 31 July 2015 by held detention type, individual detention facility, and gender

Onshore detention facilities and type	**Males**	**Females**	**Gender not specified**	**Total**
	n=231	**n=90**	**n=239**	***N*=560**
Wickham Point IDC	11 (4.7)	1 (1.1)	15 (6.3)	27 (4.8)
Maribyrnong IDC	24 (10.3)	19 (21.1)	18 (7.7)	61 (10.8)
Perth IDC	8 (3.4)	-	8 (3.3)	16 (2.8)
Christmas Is IDC	50 (21.6)	-	46 (19.2)	96 (17.1)
Villawood IDC	37 (16.0)	11 (12.2)	15 (6.2)	63 (11.2)
Yongah Hill IDC	25 (11.0)	-	12 (5.0)	37 (7.0)
IDCs Total	**155 (67.0)**	**31 (34.4)**	**114 (47.7)**	**300 (53.7)**
Adelaide ITA	-	-	4 (1.7)	4 (0.7)
Brisbane ITA	10 (4.5)	2 (2.2)	17 (7.1)	29 (5.2)
Melbourne ITA	14 (6.0)	21 (23.3)	30 (12.6)	65 (11.6)
ITAs Total	**24 (10.5)**	**23 (25.5)**	**51 (21.4)**	**98 (17.5)**
Sydney IRH (Total)	**1 (0.5)**	**1 (1.1)**	**1 (0.4)**	**3 (0.5)**
Wickham Pt APOD	38 (16.4)	16 (17.7)	40 (16.8)	94 (16.7)
Blaydin APOD	5 (2.1)	8 (9.0)	4 (1.7)	17 (3.0)
Inverbrackie APOD	1 (0.5)	4 (4.4)	9 (3.7)	14 (2.5)
Phosphate Hill APOD	3 (1.2)	1 (1.1)	8 (3.3)	12 (2.1)
Construction Camp APOD	4 (1.8)	6 (6.6)	12 (5.0)	22 (4.0)
APODs Total	**51 (22.0)**	**35 (39.0)**	**73 (30.5)**	**159 (28.3)**

Values are presented as number (%).

Episode rates of self-harm by held detention type and individual detention facility

Self-harm episode rates per 1000 asylum seekers (and corresponding 95% confidence intervals [CIs]) according to held detention type were ITAs: 452 episodes/1000 asylum seekers (95% CI 410-493); APODs (combined mainland and Christmas Island total): 265 episodes/1000 asylum seekers (95% CI 233-296); and IDCs: 225 episodes/1000 asylum

seekers (95% CI 195-254). In individual facilities, the episode rate was highest in: Perth IDC, 533 episodes/1000 asylum seekers (95% CI 487-578); and lowest in Yongah Hill, 91 episodes/1000 asylum seekers (5% CI 72-110) (see Table 8.2).

Table 8.2

Self-harm episode rates among asylum seekers in Australian onshore immigration detention between 1 August 2014 and 31 July 2015, as well as the average adult population figures, by held detention type and individual detention facility

Onshore detention facilities and type	**Average adult population figures***	**Episode rate/ 1000**	**CI (95%)**
Wickham Pt. IDC**	93	290	256-323
Maribyrnong IDC	119	512	467-556
Perth IDC	30	533	487-578
Christmas Island IDC	331	290	256-323
Villawood IDC	354	178	152-204
Yongah Hill IDC	406	91	72-110
IDCs Total	**1333**	**225**	**195-254**
Adelaide ITA	23	173	147-198
Brisbane ITA	62	467	425-509
Melbourne ITA	132	492	447-536
ITAs Total	**217**	**452**	**410-493**
APODs Total***	**601**	**265**	**233-296**

The DIBP [19] statistics these population figures are extracted from refer to asylum seekers as 'illegal maritime arrivals'. Total average population figures for the onshore immigration detention population displayed here vary slightly (by 1%) to those we have reported elsewhere [11] due to a lag in the DIBP's reporting of figures for individual facilities and/or held detention types. Wickham Point IDC did not record population figures from January 2015 onwards, so calculated episode rates are for a five-month period only. *** A combined self-harm episode rate was calculated for APODs on the mainland, as well as for APODs on Christmas Island. Whilst APODs on Christmas Island were reported to have closed in late 2014, self-harm incidents were recorded as occurring in these facilities after this time. CI: 95% Confidence intervals.*

Methods of self-harm by held detention type

Information regarding method(s) used to self-harm was extracted from 468 (83.5%) of the 560 episodes of self-harm among asylum seekers in the Australian onshore immigration detention population. Of the nine different types of methods identified, the three most frequently reported were: cutting (35.2%), self-battery (34.8%), and attempted hanging (11.1%) (Table 8.3).

Table 8.3

Methods of self-harm used by asylum seekers in Australian onshore immigration detention between 1 August 2014 and 31 July 2015, by held detention type

Methods of self-harm	**IDCs** **n=270**	**APODs** **n=123**	**ITAs** **n=75**	**Total** ***N*=468**
Cutting	109 (40.3)	31 (25.2)	25 (33.3)	165 (35.2)
Self-battery	92 (34.0)	45 (36.5)	26 (34.6)	163 (34.8)
Hanging	30 (11.1)	13 (10.5)	9 (12.0)	52 (11.1)
Self-poisoning (medication)	16 (6.0)	18 (14.6)	4 (5.3)	38 (8.1)
Self-poisoning (chemicals)	8 (3.0)	10 (8.1)	7 (9.3)	25 (5.3)
Ingesting foreign object	6 (2.2)	2 (1.6)	-	8 (2.0)
Burning	6 (2.2)	-	3 (4.0)	9 (1.9)
Lip sewing	3 (1.1)	-	-	3 (0.6)
Jumping from height	-	4 (3.2)	1 (1.3)	5 (1.0)

IDCs: Immigration detention centres; APODs: Alternative places of detention; ITAs: Immigration transit accommodation. Values are presented as number (%).

Site of injury

The site of bodily injury was extracted from 346 (74.0%) of the 468 self-harm episodes where method was known (excluding episodes of self-poisoning by medication, chemicals, and ingesting foreign objects). The head was the most common site of injury across all held detention types (143 episodes, 41.3%), followed by the wrist and arm (103 episodes, 30.0%), and the neck (50 episodes, 14.3%). Table 8.4 shows what is known about site of bodily injury, by held detention type.

Table 8.4

Site of bodily injury in self-harm episodes recorded as occurring in the Australian onshore immigration detention population in the 12 months to 31 July 2015, by held detention type

Site of bodily injury	**IDCs** **n=209**	**APODs** **n=83**	**ITAs** **n=54**	**Total** ***N*=346**
Head	77 (37.0)	44 (53.0)	22 (40.7)	143 (41.3)
Wrist and arm	69 (33.0)	18 (21.8)	16 (29.6)	103 (30.0)
Neck	31 (14.8)	12 (14.4)	7 (12.9)	50 (14.3)
Hand and fingers	24 (11.4)	7 (8.4)	4 (7.4)	35 (10.0)
Chest and torso	2 (1.0)	-	2 (3.7)	4 (1.1)
Stomach	3 (1.4)	2 (2.4)	-	5 (1.4)
Leg	3 (1.4)	-	2 (3.7)	5 (1.4)
Foot	-	-	1 (2.0)	1 (0.5)

IDCs: Immigration detention centres; APODs: Alternative places of detention; ITAs: Immigration transit accommodation. Values are presented as number (%).

8.5 Discussion

To our knowledge, this is the first examination of the variation in the incidence and method(s) of self-harm among asylum seekers in the Australian onshore immigration detention population by held detention type, as well as for each individual facility comprising each type. Between 1 August 2014 and 31 July 2015, there were 560 episodes of self-harm among asylum seekers in Australian onshore immigration detention**.** Calculated individual facility rates ranged from 91 episodes/1000 detained asylum seekers (Yongah Hill IDC) to 533 episodes/1000 asylum seekers (Perth IDC). On average, self-harm episode rates were highest among asylum seekers in ITAs (452 episodes/1000 asylum seekers), followed by APODs (265 episodes/1000 asylum seekers), and IDCs (225 episodes/1000 asylum seekers). Across all three types of held detention, cutting, self-battery, and attempted hanging were the three most frequently reported methods used to self-harm.

Rates of self-harm

The episode rates of self-harm we have calculated for all three types of held immigration detention are considerably higher than the episode rates of hospital-treated self-harm – 1.2 per 1000 – in the general Australian community during a similar period [22]. Calculated self-harm episode rates among asylum seekers detained in IDCs, APODs and ITAs are therefore 187 times, 220 times and 376 times the hospital-treated rates of self-harm in the general Australian community, respectively. These findings are consistent with previous research [6, 12], including our own [10-11], which highlights that detained asylum seekers are at an elevated risk of self-harm in comparison to the general community. The findings of the present study also extend upon earlier research, by highlighting that rates of self-harm in asylum seekers across all three types of held onshore immigration detention in Australia are exceptionally high in comparison with rates found in the general community.

Rates of self-harm in the three main types of held detention

Whilst self-harm episode rates for asylum seekers across all three main types of held immigration detention were markedly higher than hospital-treated rates of self-harm in the general Australian population, interestingly, average self-harm rates were not lower in types of detention with lower security arrangements. Indeed, it might be expected that lower security facilities, with less stringent security features, and more flexible accommodation, for families or other vulnerable individuals, might be associated with a lowered risk of self-harm in asylum seekers. However, this was not the pattern observed in the present study: on average, self-harm episode rates were highest in ITAs (452 episodes/1000 asylum seekers), followed by APODs (265 episodes/1000 asylum seekers), the two types of detention with lower security, and purportedly more flexible accommodation arrangements. These findings expand upon earlier understandings of self-harm risk among detained asylum seekers [6, 12], including our own research [10-11], to highlight that types of detention may differentially impact on self-harm risk among asylum seekers. What these findings speak to, consistent with research from the prison literature [14-15], is that whilst detention increases the overall risk of self-harm, particular features of detention environments are associated with such risk. Drawing out the particular features of the detention arrangements that may have influenced the rates of self-harm found in the present study may help guide future self-harm prevention strategies among asylum seekers, and are therefore important to highlight.

Rates of self-harm among asylum seekers held in ITAs

Whilst ITAs were originally designed as low security short-term detention facilities for people who arrived by air, but who were not immigration cleared [23], they were subsequently expanded to include asylum seekers who arrived by boat, including children [24]. Individuals may be held in ITAs whilst in transit (for example, whilst awaiting medical treatment - including those transferred from Nauru or Manus Island - or accompanying a

family member who is receiving treatment, prior to being transferred to another onshore or offshore facility), or on a short-term or long-term basis, whilst awaiting the processing of an asylum claim [24]. Research from the prison literature [14] has observed that rates of self-harm among incarcerated adults are highest among those who are detained in environments that contain mixed populations (for example, facility types housing both men and women, with large age ranges, and including remand and sentenced detainees), or when length or duration is uncertain (such as transit or remand accommodation) [15]. As the ITAs contain very mixed populations, housed for short, medium and long-term periods, it is plausible that these features of the detention environment may have contributed to the high rates of self-harm found in these types of detention. As the prison literature also indicates that rates of self-harm maybe higher in more secure facilities (particularly for men) [14], however, our findings are only partially consistent with such research. The underlying gender composition of those detained in ITAs during the study period may have influenced the pattern of findings observed in our study. Further research is needed to better understand self-harm risk, including the gendered dimensions of such risk, by held detention type.

Prior research has also documented that the practice of transferring asylum seekers between or within facilities, without adequate time to inform family, friends or legal representatives, often resulting in the separation of family members, causes significant distress [5], and may precipitate episodes of self-harm [10]. Given these same conditions and practices are found in ITAs, it is likely that these may also have influenced the high rates of self-harm identified in the present study among asylum seekers held in ITAs. Whilst the practice of transferring asylum seekers between or within facilities occurs across the immigration detention network, the mix of individuals in the populations at ITAs, as well as the circumstances of their internment, is more diverse than in other detention types.

In short, there are a range of distinct features associated with ITAs – diverse, mixed populations, detained for variable amounts of time, and for a range of reasons, and with frequent separations from family for unknown amounts of time. As these are features of detention environments that have previously been established to cause distress, and precipitate self-harm in detained populations, they are likely to also have influenced the high rates of self-harm found among those detained in ITAs in the current study. It is also conceivable that the lower levels of security in such facilities also provided individuals with greater opportunity to self-harm (easier access to means, less observation or possibility of being detected, for example).

Rates of self-harm among asylum seekers held in APODs

APODs are places designated by the DIBP to be used for detaining asylum seekers that are less secure than other types of held detention, and purportedly have a more domestic environment (generally for housing children and families), to allow more privacy, and the opportunity to do things together [4]. Reports [5, 25] from the period in question indicate, however, that APODs were often immigration detention centres that were given a number of superficial improvements (for example, being cleaned and made more functional) and accompanied by a name change. Testimonies from mental health clinicians who have worked in APODs have also highlighted that whilst APODs were meant to provide a more supportive environment for the most vulnerable asylum seekers (including children and families), these closed, institutionalised environments were not conducive to managing the health of those held there [25].

Furthermore, as canvassed at length in the 2014 Australian Human Rights Commission [AHRC] National Inquiry into Children in Immigration Detention [5], closed detention environments, such as APODs, often result in parental disempowerment, as parents are not allowed control or authority, even over the most routine of everyday matters, such as

accessing nappies, bottles and baby food, to other matters, such as decisions regarding schooling. As reported by the AHRC [5], for example, children detained in Christmas Island (APODs) had almost no school education between July 2013 to July 2014, something parents were powerless to alter. Indeed, the observations of those who have worked in APODs [25] have further highlighted that 'this lack of autonomy frequently became distressing for parents'…with 'children quickly becoming aware of this distress, which in turn created what could be described as self-perpetuating distress and helplessness about parenting, roles and attachment' (p. 526). Additional features of APODs observed to impact on the mental health of those detained there include serious concerns around child protection, including notifications and inadequate responses to reports of child abuse [5, 25].

The use of hotels, motels, and other temporary forms of accommodation as places of long-term detention for adults, as well as families with children, without adequate access to family, legal and social supports or mental or physical health treatment is another characteristic of APODs known to detrimentally impact on the mental health of those detained under such arrangements [26]. The practice of using hotels as places of long-term detention with extremely restrictive conditions, particularly for asylum seekers transferred to Australia from Nauru and Manus Island for medical treatment, has increased in recent years; the mental and physical health consequences of such detention arrangements are deeply concerning and warrant urgent investigation [26]. In short, it is plausible that the features associated with APODS that were found to impact on the mental health of those detained there, as outlined above, may have also influenced the high rates of self-harm found in these particular types of detention.

Rates of self-harm among asylum seekers held in IDCs

Whilst average self-harm episode rates in IDCs (225 episodes/1000 asylum seekers) were lower than rates identified among asylum seekers in ITAs and APODs, both the lowest and

highest self-harm episode rates were identified as occurring in IDC facilities, highlighting a large intra type range. The lower overall self-harm episode rates identified among asylum seekers in IDCs in the present study, compared with rates found in asylum seekers in ITAs, could relate to the fact that closed, secure environments, with more surveillance and staffing levels, mean that self-harm can be more closely monitored and controlled. More specifically, the stricter monitoring and surveillance of asylum seekers in IDCs may have provided fewer opportunities for self-harm attempts or threats to go unnoticed by staff. In addition to this, repeat occurrences of self-harm may be more easily 'prevented' in these more secure facilities, by using self-harm management practices, where security guards are placed 'at arms-length' of an asylum seeker for long periods following an episode of self-harm, to prevent another episode from occurring [27]. Such practices are commonly used in IDCs, and have been characterised as a form of risk management from a 'security' perspective, rather than a clinical perspective [27]. In short, it is conceivable that the lower overall episode rates of self-harm found in IDCs, compared with those found in ITAs, could relate to the design features of IDC facilities, the higher levels of monitoring and control, as well as the types of risk management strategies used more frequently in IDCs than in other types of held detention.

Rates of self-harm by individual facilities

Individual facility self-harm episode rates ranged from 91 per 1000 detained asylum seekers in Yongah Hill IDC to 533 per 1000 in Perth IDC, highlighting both a large inter- and intra-facility range. Perth IDC – the individual facility with the highest self-harm rates – is primarily used to house asylum seekers who were transferred to Perth for medical treatment [28]. This includes transfers from Christmas Island (2600 kms from Perth), Curtin IDC, as well as from Nauru and Manus Island, which highlights the large distance asylum seekers need to be transported if they require important medical treatment. It is plausible, therefore,

that the high episodes rates of self-harm identified among asylum seekers in the Perth IDC in the present study may have been associated with the specific conditions of this facility, including its remoteness of location (from other facilities), and the need to be transported from other facilities to be housed there – all factors previously found to cause mental distress [5], and precipitate self-harm episodes in detained asylum seekers in Australia [10]. As the population figures in Perth IDC were very low, however, it is possible that a few frequently self-harming individuals could have increased the self-harm rate identified in this facility. The high rates identified may also relate to the fact that individuals who were mentally unwell were transferred to Perth IDC from Christmas Island, Nauru or Manus Island, in order to receive psychiatric assessment on the mainland. This means that parts of the asylum seeker population in Perth IDC may have been a selected group of particularly unwell people.

It is important to note that the lowest individual facility self-harm episode rate identified in the present study among asylum seekers held in Yongah Hill IDC – 91 per 1000 detained asylum seekers – was calculated as 75 times the Australian community rate of hospital treated self-harm during the same period [22]. These findings very sharply illuminate the difference between the health of asylum seekers in Australian immigration detention facilities, using self-harm as a measure of health, and the health of Australians in the general community.

Methods of self-harm

The three most frequently reported methods of self-harm across the three main types of closed immigration detention were cutting, self-battery and hanging. Similarly, the three most common sites of bodily injury were consistent across the three types of closed detention: head, wrist/arm, and neck. The current findings are consistent with previous research which has documented high rates of hanging among asylum seekers detained in onshore immigration detention [10], as well as our recent research which identified high rates of hanging among both male and female asylum seekers in the Australian onshore detention

population [11]. What the current findings allow us to further discern is that approximately 1 in 10 self-harm incidents in each of the three types of closed immigration detention in Australia involved hanging. As research has established that hanging is strongly associated with an elevated risk of suicide [29], the high rates of hanging – observed across all three types of closed onshore immigration detention in the current study – clearly has serious implications for the safety of asylum seekers across the entire Australian onshore immigration detention population.

Strengths and limitations

Our study had a number of important strengths. Firstly, these are the first published data examining self-harm among asylum seekers in Australian onshore immigration detention, by held detention type, as well as individual facility. Secondly, we had access – under Freedom of Information laws – to all self-harm incidents from across the entire Australian onshore detention population, as reported to, and archived by, the (then-called) DIBP. Thirdly, our sample was large, and permitted us to examine not only the incidence of self-harm by detention type, and individual facility, but also the characteristics of self-harm, including method(s) used to self-harm, as well as the site of bodily injury – the first published data of this kind.

Our study also had several limitations. The number of unrecorded self-harm episodes among asylum seekers in Australian onshore immigration detention is unknown. It is likely, therefore, that the rates reported here understate the incidence of self-harm among asylum seekers detained in Australia. Details regarding age or country of origin, including by each detention type, and at the individual facility level, were not able to be ascertained from the incident reports. Furthermore, gender was only able to be determined in just over half of all cases. This meant that we were not able to reliably calculate rates of self-harm by held detention type or individual facility, according to gender. Lastly, as the population figures in

Perth IDC were very low, it is possible that a few frequently self-harming individuals could have increased the self-harm rate identified in this facility.

8.6 Conclusions

Our findings illustrate the far-reaching detrimental impact that Australian onshore immigration detention has on the mental health of asylum seekers, specifically in relation to self-harm. They also highlight the particular influence that different types of held immigration detention, as well as individual facilities – and their associated features, practices and policies – may have on the health of detained asylum seekers. In conclusion, the independent surveillance and monitoring of self-harm among asylum seekers detained in Australian immigration detention – the first step in any national self-harm prevention strategy [30] – must be established in order to strengthen the data that can be used to address this major public health concern.

Abbreviations

APODs: Alternative Places of Detention

AHRC: Australian Human Rights Commission

CI: Confidence Intervals

DIBP: Department of Immigration and Border Protection

FOI/A: Freedom of Information Act

IDC: Immigration Detention Centre

IRH: Immigration Residential Housing

ITA: Immigration Transit Accommodation

Declarations

Ethics approval and consent to participate

Ethics approval for this study was obtained from the University of Melbourne's Human Research Ethics Committee (#1749949.1). The research was therefore performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments.

Consent to publish

Not applicable.

Availability of data and materials

The dataset that supports the current findings was generated by data accessed via the DIBP's Freedom of Information Disclosure log (2017) on 3 April 2017, located at: https://www.homeaffairs.gov.au/access-and-accountability/freedom-of-information/disclosure-logs.

Competing interests

KH is the founder of Community-Minded Psychological Services, a private practice for people from immigrant, asylum seeking and refugee backgrounds in Melbourne, Australia, which has received funding from the Australian government to provide psychological support to asylum seekers. GC is employed at the Victoria Foundation for Survivors of Torture (Foundation House), an organisation which receives funding from the Australian government to provide psychological assistance to asylum seekers, including those in immigration detention. GC has been contracted by the Australian government's Department of Home Affairs to provide training in relation to the psychological aspects of refugee status determination. KH has been contracted by the Australian government's Department of Home Affairs to conduct independent mental health assessments and write psychological reports for

the purposes of refugee status determination for asylum seekers who have been detained in offshore detention. This research was conducted in their personal capacity, however, and the views expressed here are their own, and those of their co-authors. RB and GA declare that they have no conflicts of interest.

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Authors' contributions

KH conceived of the study, collected the data, conducted the analyses and wrote the first draft of the manuscript. GA, GC, and RB assisted with the analysis and interpretation of the results, and contributed to subsequent drafts. All authors approved the final manuscript.

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Chapter 9: Temporal variations in the distribution of self-harm episodes and methods across the Australian asylum seeker population: An observational study

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9.1 Abstract

Background: Temporal patterns in the frequency and characteristics of self-harm episodes across the Australian asylum seeker population may have implications for self-harm prevention and public health policy. The aim of this study was to examine how the distribution of self-harm episodes and method(s) of self-harm used across the Australian asylum seeker population vary according to the 24-hour cycle, day, and month, and to establish a basis for further research.

*Methods and findings***:** We conducted an observational study of all 949 self-harm incidents reported across the Australian asylum seeker population (representing a monthly average of 28,992 adults) between 1 August 2014 and 31 July 2015, obtained by Freedom of Information (FOI) from the Department of Immigration. Time of self-harm, day, and month of occurrence were investigated across all five Australian asylum seeker populations (i.e., community-based arrangements, community detention, onshore immigration detention, offshore immigration detention [Nauru], and offshore immigration detention [Manus Island]). Significant variations in distributions over the 24-hour cycle were observed by processing arrangements. Compared with the average distribution across all other processing arrangements, self-harm more commonly occurred among community-based asylum seekers (36.3%) between 12:00 AM and 3:59 AM ($p < 0.001$), in asylum seekers on Manus Island (36.4%) between 4:00 PM and 7:59 PM ($p = 0.02$), and among asylum seekers in onshore detention (20.4%) between 8:00 PM and 11:59 PM ($p < 0.001$). Compared with the average distribution across all other methods, self-poisoning (by medication) (25%) was significantly more likely to occur between 12:00 AM and 3:59 AM ($p = 0.009$), and self-battery (42%) between 8:00 AM and 11:59 AM ($p < 0.001$). The highest and lowest monthly self-harm episode rates for the whole asylum seeker population were in August (2014) (5 episodes per 1,000 asylum seekers; 95% confidence interval [CI] 1–11) and in both January and February (2015) (2.1 episodes per

1,000 asylum seekers; 95% CI 0.6–7.2), respectively; however, the overlapping CIs indicate no statistically significant differences across the months. When examining monthly trends by processing arrangements, we observed that self-harm was significantly more likely to occur in August (2014) than other months of the year among asylum seekers in onshore detention (19%) ($p < 0.001$), in January (2015) on Manus Island (18%) ($p = 0.002$), and in October (2014) on Nauru (15%) ($p < 0.001$). The main study limitations were that we could not investigate certain characteristics associated with self-harm (e.g., gender, country of origin), as the Department of Immigration did not routinely collect such data. There was also the potential risk of making a type 1 error, given the exploratory nature of the comparisons we undertook; we minimised this by lowering our significance threshold from 0.05 to 0.01.

Conclusions: Self-harm in the Australian asylum seeker population was found to vary according to time of day and month of the year, by processing arrangements. A series of procedure-related and detention-related factors were observed to be associated with the temporal variations in self-harm. These findings should form the basis for further investigation into temporal variations in self-harm among asylum seekers, which may in turn lead to effective self-harm prevention strategies.

Author Summary

Why was this study done?

- Research indicates that the mental health of asylum seekers is affected by stressors experienced before, during, and after the migration process; however, until recently, little has been known about self-harm among asylum seekers, due to the lack of accessible data.
- Research in 2019 has shown that rates of self-harm among people seeking asylum in Australia, including those on the Pacific island nation of Nauru and Manus Island

(Papua New Guinea), are exceptionally high compared with the general Australian community.

- This research tells us about the extent of self-harm in asylum seekers, but it does not tell us anything about the timing of these self-harm episodes. Information about when self-harm occurs might highlight particular stressors, including those related to policies, practices, or the environment, which could then be targeted to reduce self-harm in future.

What did the researchers do and find?

- We examined all self-harm incidents that were reported as occurring in the Australian asylum seeker population from 1 August 2014 to 31 July 2015, obtained via Freedom of Information (N = 949). Time of the day, day of the week, and month of the year were investigated in all 949 incidents, according to the five detained and community-based asylum seeker populations in Australia (including Nauru and Manus Island).
- Significant variations in the distribution of self-harm over the 24-hour cycle were observed across some asylum seeker populations.
- While for the entire asylum seeker population there were no significant variations in rates of self-harm by month of the year, self-harm was significantly more likely to occur in August 2014 (than other months of the year) among asylum seekers in onshore detention (19%), in January 2015 on Manus Island (18%), and in October 2014 on Nauru (15%). Compared with all other methods, self-poisoning (by medication) (25%) was significantly more likely to occur between 12:00 AM and 3:59 AM, and self-battery (42%) between 8:00 AM and 11:59 AM.

What do these findings mean?

- In this study, we observed that self-harm varied according to time of day, and month of the year, including by the different asylum seeker populations.
- Future research should examine these temporal trends in further detail, in order to inform self-harm prevention strategies, including those at the policy level.
- Ongoing self-harm monitoring practices should be established to more closely track and identify temporal (and other) trends, in order to protect asylum seekers from further harm.

9.2 Introduction

Global and regional conflicts have resulted in an increase in the numbers of forcibly displaced people worldwide [1]. It is now established practice for many countries to detain asylum seekers whilst their claims for protection are processed [2]. Australia has had a policy of mandatory immigration detention for all 'unlawful non-citizens', which includes those seeking asylum, for over 25 years [3]. Since August 2012, asylum seekers who arrived by boat have been subject to offshore processing on the Pacific island nation of Nauru and Manus Island, Papua New Guinea (PNG) [4]. From late 2012 onwards, depending on mode and date of arrival, there have been five main Australian asylum seeker populations, categorised according to processing arrangements: (a) community-based asylum seekers; (b) those who are held in community detention; (c) those held in onshore immigration detention (which includes centres on the Australian mainland as well as on Christmas Island, a remote island located in the Indian Ocean); (d) those who are held in offshore immigration detention on Nauru; and (e) those held in offshore immigration detention on Manus Island [5].

Offshore processing on Nauru and Manus Island has been the subject of sustained commentary and criticism in recent years [4]. This has been mainly due to the remote

location of both islands, poor detention conditions, the indefinite length of detention for asylum seekers held there, lack of access to adequate legal assistance, and limited resettlement options for asylum seekers and refugees [4]. The standard and accessibility of mental and primary healthcare services in detention centres have also been queried by health and human rights organisations [4,6]. Physical and sexual violence against asylum seekers and refugees on Nauru and Manus has also been reported [7]. A number of similar concerns regarding conditions in onshore immigration detention on the Australian mainland (including Christmas Island) have also been made by a range of allied health professionals, academics, as well as human rights organisations and other relevant health bodies [8]. Conditions in community detention (where asylum seekers—generally vulnerable adults, and families—are required to reside in a specified location, with strict supervision requirements) and for community-based asylum seekers (who may live in a place of their own choosing) are likely to mitigate some of the harms associated with closed immigration detention. Concerns regarding the impact of restrictions associated with both of these types of community-based processing arrangements, however, such as limitations on study and work rights, no or intermittent access to healthcare, access to legal support, little or no income support, food insecurity, as well as insecurity of housing for some community-based asylum seekers, have also been frequently raised [9].

Research has consistently found that asylum seekers are vulnerable to poor mental health, including higher rates of post-traumatic stress disorder (PTSD), anxiety, and depression, compared with the general community [10]. This is due, in part, to premigration stressors, including torture and trauma. Post-migratory stress is also an important predictor of mental health problems, and in some cases, even more so than pre-migratory stress. Such stressors include traumatic flight and detention experiences, prolonged separation from family, and visa, housing, food, and employment insecurity [10]. Until recently, however, knowledge

about the epidemiology of self-harm among asylum seekers has been limited, mainly as a consequence of the lack of accessible data [5].

Following the release of the largest set of de-identified self-harm data from across the entire Australian asylum seeker population via Freedom of Information (FOI)—and the first since offshore processing recommenced in late 2012—we recently investigated the episode rates and characteristics of self-harm across the entire Australian asylum seeker population between 1 August 2014 and 31 July 2015 [5]. This research—involving the same cohort and time frame of relevance to the present study—highlighted the extraordinarily high rates of self-harm among detained asylum seekers in comparison with rates found among the general Australian community, and in asylum seekers in community-based settings [5]. Calculated annual episode rates of self-harm among asylum seekers in Manus Island (54 per 1,000 detained asylum seekers), onshore detention (257 per 1,000 detained asylum seekers), and Nauru (260 per 1,000 detained asylum seekers) were 45 times, 214 times, and 216 times the Australian hospital-treated rates for self-harm, respectively [5]. By comparison, episode rates among asylum seekers in community-based arrangements (5 per 1,000) and community detention (27 per 1,000) for this one-year period were 4 and 22 times the Australian community rates for hospital-treated self-harm, respectively [5]. As we strongly asserted [5], these findings highlight the deleterious effects of immigration detention on the health of asylum seekers and warrant urgent attention.

Whilst our earlier findings demonstrate that asylum seekers, particularly those in held or ‘closed’ detention, are at a higher risk of self-harm than asylum seekers in community-based settings, they do not provide us with information about the timing of these self-harm episodes or thus any details about the potential association with policies, conditions, or practices that increase asylum seekers’ vulnerability. As knowledge of this type may guide the development of self-harm prevention strategies, including at the national policy level, the

timing of self-harm episodes would seem important to explore. According to self-harm reporting guidelines from the World Health Organization (WHO) [11]—outlined in a detailed practice manual—there are a number of core self-harm data items that should be routinely collected and reported on by countries 'to guide and prioritise the best interventions in each context and contribute to an effective… self-harm prevention strategy' (p. 3). Prevention strategies include those related to public policy [11]. Three of the core WHO data items of relevance to the Australian asylum seeker population focus on the temporal dimensions of self-harm: time of self-harm, day of the week, and date (including month of the year) [11]. As we have argued elsewhere [12], the independent monitoring of self-harm among asylum seekers in Australia, in accordance with WHO self-harm reporting guidelines, is urgently needed to highlight trends and develop prevention strategies, but is not being conducted. The aim of this exploratory study, consequently, was to examine how the distribution of self-harm episodes, and method(s) of self-harm used across the Australian asylum seeker population, vary according to the 24-hour cycle, day of the week, and month of the year, including by processing arrangements, and to establish a basis for further research and self-harm monitoring practices, which in turn may be used to inform future self-harm prevention strategies.

9.3 Methods

This study is reported as per the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guideline.

All self-harm incidents reported in the Australian asylum seeker population between 1 August 2014 and 31 July 2015 were obtained under the *Freedom of Information Act* (Commonwealth of Australia) [13], after being de-identified and published on the FOI disclosure log of the (then-called) Department of Immigration and Border Protection (DIBP)

[14]. Ethics approval for this study was granted by the University of Melbourne's Human Research Ethics Committee (#1749949.1).

Self-harm is defined as all forms of intentional self-injury (or self-poisoning), irrespective of suicidal intent or motivation [15,5]. Based on the contractual obligations the DIBP has with detention centre and community-based staff or contractors, all episodes of self-harm in the Australian asylum seeker population are required to be reported verbally to a duty manager within 30 minutes, and in writing on an incident report form within three hours [15]. The incident reports are then entered into the DIBP's incident management portal, where they are archived. Internal guidelines released on the DIBP's FOI disclosure log [14] indicate that the reports are supposed to contain a description of the self-harm incident, the nature of the injury and method used, and the incident's time and place, as well as any action taken. As highlighted elsewhere [5], it is possible that self-harm incidents in the Australian asylum seeker population are underreported due to data management, supervision, and recording practices. Furthermore, as most self-harm does not lead to medical-help seeking, it is almost certainly underreported in this context [5]. Instances of suicide were not included in the analysis, as deaths are not recorded in this category of incident reports. The most definitive record of deaths amongst Australian asylum seekers—the Australian Border Deaths Observatory [16]—indicates there were six deaths between 1 August 2014 and 31 July 2015, of which three were recorded as suicides.

The methodological approach used in the present study was content analysis. Parts of this methodology have been described elsewhere [5]. Each of the self-harm incident reports were categorised according to processing arrangement (that is, community-based arrangements, community detention, onshore detention, offshore detention [Nauru], and offshore detention [Manus Island]), method(s) used to self-harm, time of self-harm episode, day of the week, month, and gender. Time, date, and month of self-harm episode were obtained from the

information routinely entered on each incident report, and day of the week was extrapolated from this information. Given that the self-harm incident reports did not contain a gender tick box, gender was coded following a qualitative analysis of the text in each report. Cases for which gender was not able to be established were classified as a distinct category of 'gender not known'. As a reliability check, an independent coder was used to assess the way a subsample of 100 incident reports were categorised. The inter-rater reliability was found to be very high (kappa = 0.95) [17] and, on that basis, all remaining events were coded by a single coder only. Table 9.1 outlines the estimated average adult population figures for the 12-month period by processing arrangements and gender, according to the DIBP's [18] statistics.

Table 9.1

Monthly average number of adults in the Australian asylum seeker population between 1 August 2014 and 31 July 2015, by processing arrangements and gender

Processing arrangements	**Male population**	**Female population**	**Total population****
Community-based	21,136	2,758	23,894
Community detention	622	569	1,191
Onshore detention	1,815	361	2,176
Nauru	564	159	723
Manus Island*	1,008	-	1,008

*Manus Island houses only male asylum seekers. ** The total average population figures reported here vary slightly (by <0.03%) to those we have reported elsewhere [5] due to a lag in the DIBP's monthly versus annual reporting processes, including across locations.

Abbreviation: DIBP, Department of Immigration and Border Protection

Data were analysed using SPSS version 24 (IBM, Armonk, NY). Chi-squared tests were used to establish whether the observed differences between characteristics and temporal patterns were statistically significant. In order to reduce the potential risk of type 1 errors, given the number of exploratory comparisons undertaken, we lowered our significance threshold from

0.05 to 0.01 [19]. Monthly episode rates of self-harm per 1,000 asylum seekers were calculated for the total asylum seeker population, as well as for three of the five main populations, according to the DIBP's [18] statistics, with 95% confidence intervals (CI) based on Poisson distribution. Numbers were too low to calculate monthly episode rates for community detention. The monthly episode rates of self-harm (with 95% CIs) are displayed in S9.1 Table and S9.2 Table. Time of day was divided into six 4-hour intervals: 12:00 AM–3:59 AM, 4:00 AM–7:59 AM, 8:00 AM–11:59 AM, 12:00 PM–3:59 PM, 4:00 PM–7:59 PM, and 8:00 PM–11:59 PM.

No prospective analytic protocol was created. The main research question regarding the temporal variations in self-harm by the 24-hour cycle, day, and month of the year—and self-harm methods used across these temporal dimensions—was formulated prior to data inspection and from the literature highlighted in the introduction. Subsequent analyses were also planned to disaggregate the analyses by processing arrangements, given our previous findings [5] that the self-harm episode rates varied substantially across the different settings. Initial inspections of our statistically significant results showed that all except one had *p*-values of <0.001. Given the number of comparisons made, however, there was the potential risk of making a type 1 error. In response to reviewer feedback about this, we subsequently lowered our significance threshold from 0.05 to 0.01. We also supplemented the core results with monthly episode rates of self-harm in order to support the variations in distributions found, based on reviewer comments.

9.4 Results

Study sample

During the 12-month period from 1 August 2014 to 31 July 2015, a total of 949 episodes of self-harm were recorded as occurring across the entire Australian asylum seeker population. Of the 949 episodes of self-harm, 560 episodes (59.0%) involved the 2,176 asylum seekers

detained in onshore immigration detention, 188 episodes (19.8%) involved the 723 asylum seekers held on Nauru, 113 episodes (11.9%) involved the 23,894 asylum seekers in community-based arrangements, 55 episodes (5.8%) involved the 1,008 asylum seekers held on Manus Island, and 33 episodes (3.5%) involved the 1,191 asylum seekers held in community detention. Details regarding gender were able to be extracted from 590 (62.1%) of the 949 self-harm incident reports. Gender was not able to be determined in 359 (37.9%) episodes. Males were involved in 426 (72.2%) self-harm episodes (where gender was able to be determined) and females in 164 (27.8%). No children or adolescents were included in the study sample, as data pertaining to minors were not available. Information regarding country of origin, age, date of birth, length of detention, psychiatric history, or suicidal intent was not able to be extracted from the self-harm incident reports.

The proportion of self-harm episodes by 24-hour cycle

The time of occurrence was recorded for all 949 self-harm episodes (Table 9.2). Self-harm was found to vary according to time of day across the Australian asylum seeker population (χ^2 [20, N = 949] = 107.2, $p < 0.001$). On average, across all processing arrangements self-harm most commonly occurred across two consecutive four-hour intervals—between 12:00 PM and 7:59 PM—during which time 46.2% of all self-harm episodes (n = 438) occurred. The peak time was between 12:00 PM and 3:59 PM, when 25.3% of all self-harm episodes (n = 240) occurred. The trough in self-harm episodes occurred between 4:00 AM and 7:59 AM, during which time 6.8% of all self-harm episodes (n = 65) occurred. Following this time, self-harm episodes increased in frequency until the late afternoon peak time.

Table 9.2. *The number and percentage of self-harm episodes in the Australian asylum seeker population between 1 August 2014 and 31 July 2015, by processing arrangements, according to time of day, day of the week, and month of occurrence*

Number of self-harm episodes	**Onshore detention**	**Nauru**	**Manus Island**	**Community detention**	**Community -based**	***N* (%)**
	n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	
	560	**188**	**55**	**33**	**113**	**949**
Time of day						
12:00 AM–3:59 AM	49 (8.8)	25 (13.3)	6 (10.9)	5 (15.2)	41 (36.3)	126 (13.3)
4:00 AM–7:59 AM	47 (8.4)	7 (3.7)	1 (1.8)	1 (3.0)	9 (8.0)	65 (6.8)
8:00 AM–11:59 AM	93 (16.6)	28 (14.9)	6 (10.9)	6 (18.2)	19 (16.8)	152 (16.0)
12:00 PM–3:59 PM	141 (25.2)	48 (25.5)	9 (16.4)	7 (21.2)	35 (31.0)	240 (25.3)
4:00 PM–7:59 PM	116 (20.7)	49 (26.1)	20 (36.4)	7 (21.2)	6 (5.3)	198 (20.9)
8:00 PM–11:59 PM	114 (20.4)	31 (16.5)	13 (23.6)	7 (21.2)	3 (2.7)	168 (17.7)
Day						
Monday	71 (12.7)	20 (10.6)	7 (12.7)	3 (9.1)	18 (15.9)	119 (12.5)
Tuesday	86 (15.4)	28 (14.9)	7 (12.7)	8 (24.2)	20 (17.7)	149 (15.7)
Wednesday	80 (14.3)	30 (16.0)	13 (23.6)	4 (12.1)	17 (15.0)	144 (15.2)
Thursday	105 (18.8)	24 (12.8)	11 (20.0)	6 (18.2)	15 (13.3)	161 (17.0)
Friday	77 (13.8)	36 (19.1)	6 (10.9)	6 (18.2)	14 (12.4)	139 (14.6)
Saturday	76 (13.6)	26 (13.8)	6 (10.9)	1 (3.0)	13 (11.5)	122 (12.9)
Sunday	65 (11.6)	24 (12.8)	5 (9.1)	5 (15.2)	16 (14.2)	115 (12.1)
Month						
August 2014	109 (19.5)	12 (6.4)	4 (7.3)	7 (21.2)	16 (14.2)	148 (15.6)
September 2014	57 (10.2)	19 (10.1)	1 (1.8)	3 (9.1)	13 (11.5)	93 (9.8)
October 2014	30 (5.4)	29 (15.4)	1 (1.8)	2 (6.1)	17 (15.0)	79 (8.3)
November 2014	41 (7.3)	12 (6.4)	7 (12.7)	-	9 (8.0)	69 (7.3)
December 2014	40 (7.1)	12 (6.4)	6 (10.9)	1 (3.0)	10 (8.8)	69 (7.3)
January 2015	25 (4.5)	17 (9.0)	10 (18.2)	3 (9.1)	7 (6.2)	62 (6.5)
February 2015	37 (6.6)	15 (8.0)	3 (5.5)	2 (6.1)	5 (4.4)	62 (6.5)
March 2015	33 (5.9)	17 (9.0)	6 (10.9)	4 (12.1)	5 (4.4)	65 (6.8)
April 2015	48 (8.6)	15 (8.0)	2 (3.6)	2 (6.1)	3 (2.7)	70 (7.4)
May 2015	39 (7.0)	11 (5.9)	7 (12.7)	3 (9.1)	9 (8.0)	69 (7.3)
June 2015	55 (9.9)	13 (6.9)	4 (7.3)	3 (9.1)	11 (9.7)	86 (9.1)
July 2015	46 (8.2)	16 (8.5)	4 (7.3)	3 (9.1)	8 (7.1)	77 (8.1)

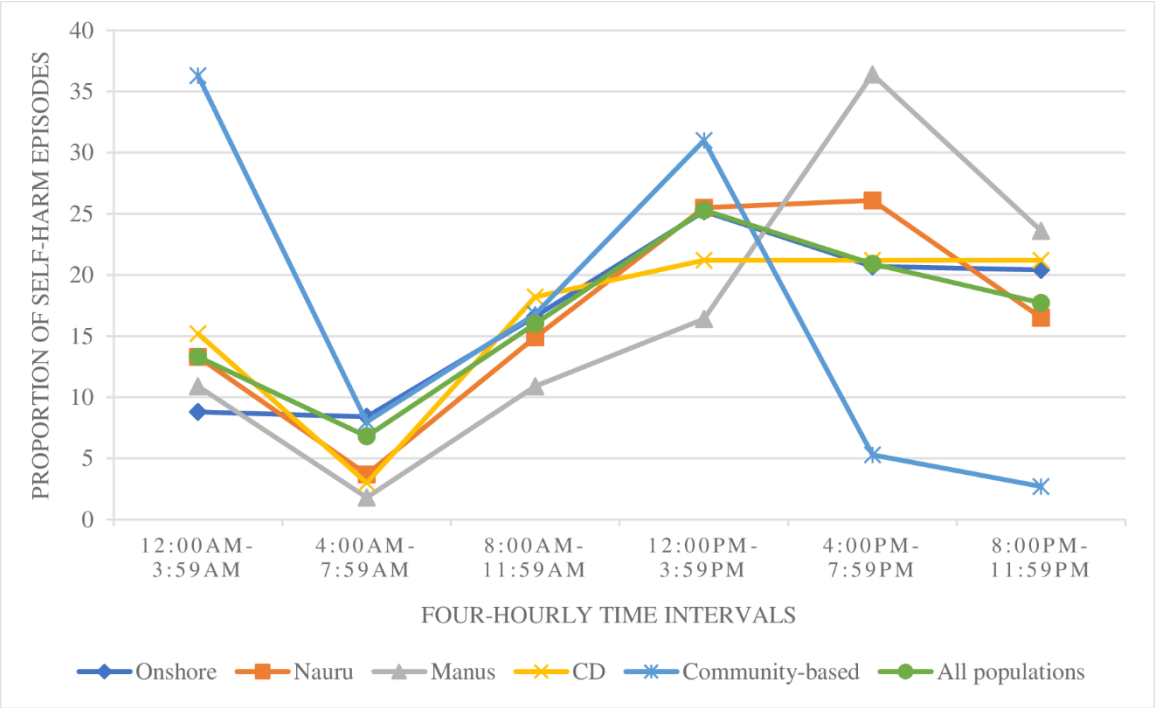
Values are presented as number (%).

The proportion of self-harm episodes by 24-hour cycle, according to processing arrangements

The four-hourly pattern of self-harm episodes was also examined according to processing arrangements. The distributions across the 24-hour cycle (by four-hourly intervals) varied markedly by processing arrangements (Figure 9.1). The pattern for community-based asylum seekers was such that self-harm more commonly occurred between 12:00 AM and 3:59 AM (36.3%), compared with the average distribution across all other processing arrangements (10.2%) (χ^2 [5, N = 949] = 84.3, $p < 0.001$). Self-harm episodes among asylum seekers in Manus Island more commonly occurred between 4:00 PM and 7:59 PM (36.4%), compared with the average distribution across all other processing arrangements (19.9%) (χ^2 [5, N = 949] = 13.0, $p = 0.02$); however, this difference did not reach statistical significance. The pattern of self-harm episodes for asylum seekers in onshore immigration detention was such that self-harm more commonly occurred between 8:00 PM and 11:59 PM (20.4%), compared with the average distribution across all other processing arrangements (13.9%) (χ^2 [5, N = 949] = 31.5, $p < 0.001$). The temporal pattern of self-harm episodes for asylum seekers in Nauru (χ^2 [5, N = 949] = 6.76, $p = 0.238$) or in community detention (χ^2 [5, N = 949] = 1.56, $p = 0.906$), however, did not differ significantly from the average distribution across all other processing arrangements.

Figure 9.1. The proportion of self-harm episodes occurring across the Australian asylum seeker population per four-hourly intervals over the 24-hour time frame, by processing arrangements.

Legend: Self-harm episodes occurring in asylum seekers in onshore detention, Nauru, Manus Island, community detention, community-based asylum seekers, as well as across the total Australian asylum seeker population, according to four-hourly intervals over the 24-hour time frame. CD, community detention



Self-harm episodes by day of the week, including by processing arrangements

The date (from which day of the week was derived) was recorded for all 949 self-harm episodes. The distribution of self-harm episodes did not vary significantly according to day of the week or by processing arrangements (χ^2 [24, N = 949] = 20.0, p = 0.693). Table 9.2 displays the proportion of self-harm episodes by day of the week, including by processing arrangements.

Self-harm episodes by month of occurrence

The month of occurrence was recorded for all 949 self-harm episodes (Table 9.2). The monthly average number of self-harm episodes across the Australian asylum seeker population was 79 (calculated by dividing the total number of episodes by 12). Nearly double the average number of self-harm episodes were recorded in August (148), with above-average numbers also recorded in September (93) and June (86). January (62) and February (62) both recorded below-average numbers. Whilst self-harm was found to occur more commonly in August compared with the distribution across all other months (χ^2 [4, N = 949] = 22, $p < 0.001$), across parts of the Australian asylum seeker population, the residuals highlight that this was only the case for asylum seekers in onshore detention and community detention. Indeed, whilst the calculated monthly episode rates per 1,000 (95% CI) for the total asylum seeker population (see Supplementary Table S9.1) show that the highest rate of self-harm occurred in August 2014 (5 episodes/1,000 asylum seekers [95% CI 1–11]), the overlapping CIs do provide a strong indication that differences across the months over the whole population are unlikely to be statistically significant.

The proportion of self-harm episodes by month of occurrence, according to processing arrangements

One fifth of all self-harm episodes in community detention (21.2%) and onshore detention (19.5%) occurred in August, close to a fifth (18.2%) of all self-harm episodes in Manus Island occurred in January, and just over a tenth of all self-harm episodes amongst community-based asylum seekers (15.0%) and in Nauru (15.4%) occurred in October (Table 9.2). Compared with the average distribution across all other processing arrangements, asylum seekers in onshore detention were significantly more likely to self-harm in August (χ^2 [11, N = 949] = 42.2, $p < 0.001$), asylum seekers in Nauru were significantly more likely to self-harm in October (χ^2 [11, N = 949] = 34.1, $p < 0.001$), and those held on Manus Island

were significantly more likely to self-harm in January (χ^2 [11, N = 949] = 29.3, p = 0.002). There were no significant differences between the average distribution across all processing arrangements and month of occurrence for community-based asylum seekers (χ^2 [11, N = 949] = 6.2, p = 0.855). Cell counts were too low to test for significant differences amongst asylum seekers in community detention by month of occurrence. Table 9.2 displays self-harm by month of occurrence, according to processing arrangements. Calculated monthly episode rates of self-harm per 1,000 (95% CI) (see Supplementary Table S9.2) by processing arrangement support the pattern of distribution observed: episode rates were highest among asylum seekers on Nauru in October (31 episodes/1,000 asylum seekers [95% CI 21–44]), on Manus Island in January (9 episodes/1,000 asylum seekers [96% CI 4–17]), and in onshore detention in August (39 episodes/1,000 asylum seekers [95% CI 27–53]).

Methods of self-harm by 24-hour cycle

Methods of self-harm were documented in 774 (81.5%) of the 949 self-harm incident reports. The three most common methods of self-harm were as follows: cutting (290 episodes, 37.4%), self-battery (199 episodes, 26.0%), and attempted hanging (83 episodes, 11.0%). Table 9.3 outlines the descriptive statistics for all methods of self-harm reported as being used among the Australian asylum seeker population during the 12-month period.

Table 9.3. *Methods of self-harm used by the Australian asylum seeker population between 1 August 2014 and 31 July 2015, according to time of day, day of the week, and month of occurrence*

Methods of self-harm	**Cutting**	**Self-battery**	**Attempt. hanging**	**Self-poisoning (medication)**	**Self-poisoning (chemical)**	**Ingest foreign object**	**Other**	***N* (%)**
	n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	
	290	**199**	**83**	**79**	**57**	**28**	**38**	**774**
Time of day								
12:00 AM–3:59 AM	38 (13.1)	9 (4.5)	15 (18.1)	20 (25.3)	7 (12.3)	3 (10.7)	4 (10.5)	96 (12.4)
4:00 AM–7:59 AM	16 (5.5)	15 (7.5)	3 (3.6)	4 (5.1)	5 (8.8)	1 (3.6)	3 (7.9)	47 (6.1)
8:00 AM–11:59 AM	50 (17.2)	42 (21.1)	9 (10.8)	8 (10.1)	8 (14.0)	4 (14.3)	6 (15.8)	127 (16.4)
12:00 PM–3:59 PM	83 (28.6)	49 (24.6)	19 (22.9)	16 (20.3)	13 (22.8)	7 (25.0)	6 (15.8)	193 (24.9)
4:00 PM–7:59 PM	57 (19.7)	40 (20.1)	22 (26.5)	15 (19.0)	15 (26.3)	10 (35.7)	12 (31.6)	171 (22.1)
8:00 PM–11:59 PM	46 (15.9)	44 (22.1)	15 (18.1)	16 (20.3)	9 (15.8)	3 (10.7)	7 (18.4)	140 (18.1)
Day								
Monday	44 (15.2)	19 (9.5)	14 (16.9)	8 (10.1)	4 (7.0)	4 (14.3)	1 (2.6)	94 (12.1)
Tuesday	44 (15.2)	19 (9.5)	16 (19.3)	12 (15.2)	12 (21.1)	2 (7.1)	10 (26.3)	115 (14.8)
Wednesday	40 (13.8)	27 (13.6)	16 (19.3)	11 (13.9)	9 (15.8)	7 (25.0)	9 (23.7)	119 (15.4)
Thursday	40 (13.8)	45 (22.6)	10 (12.0)	11 (13.9)	6 (10.5)	5 (17.9)	9 (23.7)	126 (16.3)
Friday	49 (16.9)	30 (15.1)	12 (14.5)	14 (17.7)	14 (24.6)	4 (14.3)	3 (7.9)	126 (16.3)
Saturday	39 (13.4)	32 (16.1)	10 (12.0)	11 (13.9)	6 (10.5)	2 (7.1)	3 (7.9)	103 (13.3)
Sunday	34 (11.7)	27 (13.6)	5 (6.0)	12 (15.2)	6 (10.5)	4 (14.3)	3 (7.9)	91 (11.8)
Month								
August 2014	42 (14.5)	37 (18.6)	14 (16.9)	15 (19.0)	4 (7.0)	-	6 (15.8)	118 (15.2)
September 2014	33 (11.4)	13 (6.5)	7 (8.4)	10 (12.7)	6 (10.5)	1 (3.6)	7 (18.4)	77 (9.9)
October 2014	29 (10.0)	9 (4.5)	6 (7.2)	8 (10.1)	6 (10.5)	-	-	58 (7.5)
November 2014	27 (9.3)	17 (8.5)	2 (2.4)	-	4 (7.0)	2 (7.1)	1 (2.6)	53 (6.8)
December 2014	22 (7.6)	17 (8.5)	5 (6.0)	5 (6.3)	2 (3.5)	1 (3.6)	5 (13.2)	57 (7.4)
January 2015	16 (5.5)	10 (5.0)	4 (4.8)	6 (7.6)	2 (3.5)	10 (35.7)	2 (5.3)	50 (6.5)
February 2015	21 (7.2)	19 (9.5)	3 (3.6)	3 (3.8)	3 (5.3)	3 (10.7)	2 (5.3)	54 (7.0)
March 2015	18 (6.2)	16 (8.0)	6 (7.2)	4 (5.1)	4 (7.0)	2 (7.1)	1 (2.6)	51 (6.6)
April 2015	14 (4.8)	14 (7.0)	9 (10.8)	6 (7.6)	4 (7.0)	3 (10.7)	5 (13.2)	55 (7.1)
May 2015	21 (7.2)	17 (8.5)	8 (9.6)	5 (6.3)	4 (7.0)	2 (7.1)	2 (5.3)	59 (7.6)
June 2015	29 (10.0)	15 (7.5)	8 (9.6)	7 (8.9)	11 (19.3)	2 (7.1)	3 (7.9)	75 (9.7)
July 2015	18 (6.2)	15 (7.5)	11 (13.3)	10 (12.7)	7 (12.3)	2 (7.1)	4 (10.5)	67 (8.7)

Values are presented as number (%).

Compared with the average distribution across all other methods, self-poisoning (by medication)—the fourth most common method of self-harm—was significantly more likely to occur between 12:00 AM and 3:59 AM (χ^2 [5, N = 774] = 15.4, p = 0.009), whereas self-battery was significantly more likely to occur between 8:00 AM and 11:59 AM (χ^2 [5, N = 774] = 20.8, $p \leq 0.001$). Cutting (χ^2 [5, N = 774] = 5.6, p = 0.341) and attempted hanging (χ^2 [5, N = 774] = 6.0, p = 0.300) did not vary by time of occurrence.

Methods of self-harm by day of the week, and month of occurrence

There were no significant differences in the method(s) used to self-harm by day of the week (χ^2 [36, N = 774] = 47.2, p = 0.100) or in the three most common methods of self-harm, according to month of occurrence (χ^2 [22, N = 572] = 26.1, p = 0.246). Table 9.3 displays the variations in the method(s) used to self-harm across the Australian asylum seeker population by day of the week and month of the year.

9.5 Discussion

In this exploratory study, we examined the distribution of self-harm episodes, and method(s) used to self-harm in the Australian asylum seeker population according to the 24-hour cycle, day of the week, and month of the year over a 12-month period. We observed diurnal and monthly variations in self-harm episodes across the Australian asylum seeker population, including by processing arrangements. Specifically, the four-hourly pattern for community-based asylum seekers was such that self-harm most commonly occurred between 12:00 AM and 3:59 AM, for asylum seekers on Manus Island, between 4:00 PM and 7:59 PM, and for asylum seekers in onshore immigration detention, between 8:00 PM and 11:59 PM. Two of the most common methods of self-harm—self-poisoning (by medication) and self-battery—were also found to vary according to time of the day, occurring most frequently between 12:00 AM and 3:59 AM, and 8:00 AM and 11:59 AM, respectively. Significant monthly variations in self-harm were found in Nauru (in October 2014), in Manus Island (in January

2015), and in onshore detention (in August 2014). Drawing out the features of the various detention policies, practices, and conditions that may have been associated with the observed temporal variations in self-harm in the Australian asylum seeker population may guide future research and self-harm monitoring practices. As these may in turn help to inform self-harm prevention strategies, including at the public policy level, they are important to highlight and are therefore considered in more detail below.

The largest proportion of self-harm incidents across the Australian asylum seeker population occurred between 12:00 PM and 3:59 PM, whilst the trough in self-harm incidents occurred between 4:00 AM to 7:59 AM. Nearly half (46%) of all self-harm incidents occurred between 12:00 PM and 7:59 PM. Whilst the trough in self-harm during the very early hours of the morning is consistent with previous research regarding hospital-treated self-harm presentations [20], the substantial proportion occurring across the entire asylum seeker population during business hours and in the early evening is not. Previous research regarding the timing of self-harm in hospital-treated episodes has found that the peak in self-harm most commonly occurred between 10 PM and midnight [21]. The diurnal pattern observed across the asylum seeker population as a whole is therefore more comparable with recent research from the prison population, which found that just over half (52%) of all self-harm incidents occurred between 2 PM and 8 PM [22]. Detention-specific factors such as the environment, issues related to accommodation, and legal concerns, procedure-related factors such as changes in cells or changes in security level, relationship concerns regarding family and staff, as well as mental and physical health concerns were cited as the most common contributing factors to self-harm occurring in the prison population during these hours of the day [22]. Similar precipitating factors for self-harm amongst asylum seekers in the onshore detention population have, in fact, also been previously identified, with detention-related conditions, procedure-related factors, such as claim processing times, as well as separation from family

found to be the most common precipitants [23]. Whilst the present study was not able to measure precipitants for self-harm, it is plausible that similar factors also contributed to self-harm episodes in the present study.

The four-hourly pattern of self-harm according to processing arrangements revealed some further differentiation in diurnal patterns. For community-based asylum seekers, self-harm was significantly more likely to occur between 12:00 AM and 3:59 AM, compared with the average distribution across all other arrangements, which is more consistent with late evening to early morning patterns found in hospital-treated self-harm presentations [20]. Importantly, the early morning peak in self-harm found in community-based asylum seekers highlights the disrupted sleep-wake cycles of this population. Whilst this is likely a consequence of mental health conditions such as depression and/or anxiety, precipitated by the circumstances under which community-based asylum seekers are living—outlined further below—the disrupted sleep-wake cycles are potentially more evident in community-based asylum seekers, as their evening routines are less able to be controlled than in other populations. It is important to note that community-based asylum seekers have less contact with DIBP and other contracted case workers than asylum seekers in closed detention arrangements. It is plausible, therefore, that the early morning peak in self-harm observed amongst community-based asylum seekers is partly an artefact of the reporting and supervisory practices associated with this particular population.

For asylum seekers on Manus Island, self-harm most commonly occurred between 4 PM and 7:59 PM, which is more comparable with patterns found in recent prison research [22], as highlighted above. As services and staffing levels on Manus Island have previously been identified as being inadequate [24], it is plausible that the time of day in which access to physical, mental, and other support services becomes limited corresponds to an increase in self-harm for asylum seekers held there. Furthermore, as threats to asylum seekers' safety,

including acts of violence and intimidation by locals and security personnel, have also been reported as occurring on multiple occasions on Manus Island [25], it is also possible that as the evening approaches, asylum seekers' distress and fear may intensify, thereby triggering acts of self-harm.

For asylum seekers in onshore detention, self-harm was significantly more likely to occur between 8 PM and 11:59 PM, compared with the average distribution across all other processing arrangements. Our own research has found that rates of self-harm among adult asylum seekers in onshore detention during the same study period—at 257 per 1,000 detained asylum seekers—were 214 times higher than hospital-treated rates of self-harm in the general Australian community [5]. Furthermore, our more recent study [26] has observed that self-harm episodes occur most frequently in types of onshore detention where populations are mixed (such as Immigration Transit Accommodation [ITA] and Alternative Places of Detention [APODs]). These types of detention house both single adult males and females, as well as families, for short-, medium-, and long-term stays. Transfers between and within other facilities reportedly occur very frequently in such detention arrangements—including between onshore and offshore detention—often with little notice, resulting in family separation [26]. Such separations are known to occur between parents and children, couples, as well as extended family members. There are a range of possible explanations worth considering for the observed pattern of self-harm: the state of the centres at this time of the evening, fear of transfer during the night, and lower levels of supervision. Furthermore, as both ITAs and APODs were used for housing families with children, it is likely that attempting to carry out parenting tasks in the late evening in such environments, with little autonomy or flexibility, was experienced as particularly challenging for both detained parents and children [26]. Indeed, research has found that held detention environments, including both APODs and ITAs, frequently contributed to feelings of parental disempowerment, with

parents often stripped of control over their everyday routines, including organising mealtimes in the evenings to suit children's bedtimes or easy access to bottles and nappies, as needed, including late at night [27-28]. Of relevance to the present study is that previous research has found that parental disempowerment creates ongoing feelings of distress and helplessness, leading to a deterioration in mental health [29], which in turn may precipitate acts of self-harm.

Some diurnal variations in the most common methods of self-harm used across the Australian asylum seeker population were also found in the present study. The significant increase in self-harm involving self-poisoning (by medication) between 12:00 AM and 3:59 AM, compared with all other methods, is consistent with previous research that has reported an early morning peak in self-poisoning [30]. This finding points to the disruptive sleep-wake cycles of asylum seekers self-harming during these times, which is likely a consequence of mental health conditions, such as depression and/or anxiety, as previously mentioned. As self-harm incidents between 12:00 AM and 3:59 AM were significantly more likely to occur amongst community-based asylum seekers, it is conceivable that the increase in self-poisoning by medication in this population at this time was a consequence of lower levels of supervision, as well as the greater access that community-based asylum might have to medications, compared with those in held detention.

Whilst not significant, the diurnal patterns observed in self-harm episodes involving cutting and attempted hanging—two of the four most common methods of self-harm found in the present study—are important to comment on. Nearly one in three of all self-harm incidents involving cutting occurred between 12:00 PM and 3:59 PM, whilst over a quarter of all self-harm incidents involving hanging occurred between 4:00 PM and 7:59 PM. These findings likely speak to the availability of means and likelihood of detection. The timing of self-harm incidents involving attempted hanging in the present study is also consistent with previous

research that found that individuals with higher suicidal intent were more likely to present from 4 PM until the late evening [20]. It is acknowledged that the present study cannot comment directly on suicidal intent. Further research and enhanced self-harm surveillance processes are needed in order to gain a greater awareness of the characteristics associated with self-harm episodes amongst asylum seekers.

The findings of the present study highlight a monthly variation in the distribution of self-harm across the Australian asylum seeker population during the 12-month study period, according to some processing arrangements. Self-harm was significantly more likely to occur in August 2014 amongst asylum seekers in onshore detention, in October 2014 on Nauru, and in January 2015 on Manus Island. There are a number of possible explanations for the observed monthly variation in the distribution of self-harm across the Australian asylum seeker population during the study period. The possible reintroduction of 3-year Temporary Protection Visas (TPVs), instead of permanent protection visas (PPVs), and the conditions associated with such visas were debated in parliament throughout 2014 [31]. As TPVs have previously been found to cause considerable suffering for refugees due to their being placed in a state of legal uncertainty, as well as ongoing concerns about being sent back to a country where they fear persecution [32], it is highly likely that the potential re-introduction of TPVs was experienced as an additional stressor for onshore asylum seekers at this time. For various reasons, this may have been more intensely experienced during August 2014. During this time frame, some 30,000 asylum seekers who had been impacted by a processing freeze on visas (implemented by the government in response to the Senate previously disallowing the reintroduction of TPVs in December 2013) were also waiting to see if the newly formed Senate in July–early August might lift the bar on the processing of their protection visas [33]. This processing freeze reportedly had a significant, detrimental impact on asylum seekers'

mental health during this time [29], and heightened concerns regarding whether or not it would be lifted may have contributed to the observed pattern of self-harm at this time.

For asylum seekers detained on Nauru, a number of events occurred in late September–October 2014, which likely contributed to the spike in self-harm incidents during this time. Throughout this period, there was continuing uncertainty about asylum seekers' future that may have been heightened at this time: any remaining hope about applying for an Australian visa was closed by an announcement by the Minister for Immigration in September 2014; also at this time, the Minister indicated that asylum seekers in Nauru may be resettled in Cambodia [34-37].

There are also a range of possible gender-specific stressors that may have contributed to the increases in self-harm at this time. A number of reports and inquiries into conditions in immigration detention during this time have highlighted, for example, that sexual assaults and violence against both women and children were commonplace, and likely contributing factors for acts of self-harm [7,29, 38-39]. Indeed, several allegations of sexual and physical abuse against women and children detained on Nauru were made in mid-September to early October 2014, prompting the announcement of a government investigation on 3 October, which later became the Moss review [39]. Interviews for the Moss review, with both asylum seekers and staff and contractors, took place in Nauru during 25 October–1 November and 12–19 November 2014 [39], which may have further heightened feelings of distress amongst asylum seekers at this time. Acts of sexual and physical violence against male asylum seekers, as previously mentioned, may also have contributed to the pattern of self-harm observed in the present study during these particular times. For males, particularly those detained on Manus Island, announcements regarding the first refugee status determination decisions and associated transfers to locations without adequate settlement services and

protection from locals [40] may also have been experienced as an additional stressor at this time.

For asylum seekers detained on Manus Island, unrest reported to have occurred throughout January 2015 [41-42] was likely to have contributed to increased distress and self-harm at this time. Reports from human rights organisations as well as the media indicated that asylum seekers who had been determined to be refugees were informed they were to be transferred to insecure accommodation (in Lorengau, the major town in Manus Province) on 22 January, where they feared they would be vulnerable to further attacks by locals [42]. Unrest and conflict involving up to 300 asylum seekers were subsequently reported as occurring over a number of days, with numbers on a hunger strike eventually reaching over 500 and continuing for over 10 days [42].

Future research should examine these temporal trends in further detail in order to inform self-harm prevention strategies, including those at the policy level. Such research should also more directly investigate any potential links with policies, practices, and conditions. Ongoing self-harm monitoring practices in line with WHO guidelines [11] should also be established to more closely track and identify temporal (and other) trends to protect the health and safety of asylum seekers.

It is important to mention something briefly here about understandings of self-harm. Self-harm is a behaviour, understood as a way of coping with or expressing overwhelming distress [43]. As outlined clearly by clinical experts and allied and other health professionals in Australian government inquiries into self-harm among asylum seekers, self-harm is generally observed to occur as a consequence or way of managing genuine psychological distress and not as a form of manipulative behaviour [7,15].

9.6 Strengths and limitations

Our study had a number of strengths. First, these are the first published data examining the variation in self-harm incidents and method(s) of self-harm used across the Australian asylum seeker population, by hour, day of the week, and month of occurrence, according to WHO self-harm reporting guidelines [11]. Second, we were able to access—via the *Freedom of Information Act*—all self-harm incidents recorded as occurring across the Australian asylum seeker population during the 12-month study period. Third, our sample was large and enabled us to not only examine the temporal patterns in self-harm, as well as method(s) used to self-harm across the entire Australian asylum seeker population, but also the temporal dimensions of self-harm according to each of the five main processing arrangements (i.e., community-based asylum arrangements, community detention, onshore detention, offshore detention [Nauru], and offshore detention [Manus Island]).

Our study also had some limitations. The number of unreported self-harm incidents during the study period is unknown. It is likely, therefore, that the self-harm incidents reported here are an underestimate of the real number of self-harm incidents occurring across the Australian asylum seeker population. Furthermore, some self-harm incidents, particularly those requiring little or no medical treatment, may not have come to the attention of staff immediately. Under these circumstances, it is likely that the time of occurrence logged by staff on the self-harm incident reports would have been an estimation. There was also the potential risk of making a type 1 error, given the number of exploratory comparisons we undertook, although we minimised this risk by lowering our significance threshold from 0.05 to 0.01 [19]. We were also limited in our ability to investigate certain potentially important characteristics associated with self-harm, as the DIBP did not routinely require such data to be collected. Information relating to gender, for example, could only be extracted from just over two thirds of the self-harm incident reports, meaning that some processing arrangements

had higher proportions of missing gender data than other processing arrangements. This restricted our ability to reliably investigate any further interactions between gender and temporal dimensions. Information relating to precipitating factors for self-harm was also only able to be extracted from less than 10% of all self-harm incident reports. Furthermore, whilst mental health among asylum seekers in Australian immigration detention has previously been found to deteriorate with length of detention [44], information regarding time spent in detention was not recorded on the incident reports. Identifying information such as country of origin, age, and date of birth would have been redacted prior to the incident reports being released under FOI. In addition to this, information regarding psychiatric history and suicidal intent—which have previously been found to be associated with self-harm in the general population [45]—was not able to be extracted from the self-harm incident reports. The data analysed also did not include instances of suicide, as deaths are not recorded in this category of incident reports. As noted in the Methods section, there were 3 deaths by suicide during the study period [16]. Whilst these deaths may speak to neglect and/or other forms of structural abuse, and are clearly of concern, the inclusion of these reported suicides would not be likely to impact patterns in the self-harm data, and the low number of deaths by suicide preclude analysis of temporal patterns. Lastly, the low numbers of self-harm observations meant that we were unable to detect statistically significant differences in self-harm among asylum seekers in community detention by month of occurrence. This meant that we were not able to ascertain whether self-harm among asylum seekers in community detention varied by month of the year, or make meaningful comparisons regarding monthly variations in self-harm across all processing arrangements.

9.7 Conclusions

Self-harm in the Australian asylum seeker population was found to vary according to time of day and month of the year, including by processing arrangements. Given the harms observed

across the Australian asylum seeker population—which we have previously asserted constitute a public health crisis [12]—the current findings should serve as a basis for more detailed investigation into temporal variations in self-harm among asylum seekers, which may in turn lead to effective self-harm prevention strategies.

9.8 References

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9.9 Supplementary tables

Supplementary Table S9.1

Monthly population figures, self-harm episode rates, with 95% Confidence Intervals, between 1 August 2014 and 31 July 2015, for the Australian asylum seeker population

Month of the year	Total Australian asylum seeker population	Self-harm (*N* =949)	Self-harm episode rate per 1,000	95% Confidence Intervals
AUG 2014	29062	148	5.0	1.6-11.6
SEP 2014	28961	93	3.2	1.0-8.7
OCT 2014	28979	79	2.7	0.6-7.2
NOV 2014	28960	69	2.3	0.6-7.2
DEC 2014	29037	69	2.3	0.6-7.2
JAN 2015	29001	62	2.1	0.6-7.2
FEB 2015	29038	62	2.1	0.6-7.2
MAR 2015	29014	65	2.2	0.6-7.2
APR 2015	29010	70	2.4	0.6-7.2
MAY 2015	29003	69	2.3	0.6-7.2
JUN 2015	28954	86	2.9	0.6-7.2
JUL 2015	28913	77	2.6	0.6-7.2

Supplementary Table S9.2

Monthly population figures, self-harm episode rates, with 95% Confidence Intervals, between 1 August 2014 and 31 July 2015, for asylum seekers in onshore detention, Nauru and Manus Island

Month of the year	Onshore detention population	Self-harm episodes ($N = 560$)	Episode rate of self-harm per 1,000	95% CI	Nauru population	Self-harm episodes ($N = 188$)	Episode rate of self-harm per 1,000	95% CI	Manus Island population	Self-harm episodes ($N = 55$)	Episode rate of self-harm per 1,000	95% CI
AUG 2014	2793	109	39.0	27.7-53.3	1011	12	11.8	6.2-19.6	1084	4	3.6	1.0-8.7
SEP 2014	2711	57	21.0	12.9-32.1	954	19	19.9	12.2-29.6	1060	1	0.9	0.02-3.0
OCT 2014	2525	30	12.0	6.2-20.9	928	29	31.2	21.8-44.0	1056	1	0.9	0.02-3.0
NOV 2014	2620	41	15.6	9.1-24.7	841	12	14.2	8.3-23.4	1044	7	6.7	2.8-13.0
DEC 2014	2337	40	17.1	10.6-27.2	760	12	15.7	9.1-24.7	1035	6	5.7	2.2-11.6
JAN 2015	2087	25	12.0	6.2-20.9	683	17	24.8	16.1-35.7	1023	10	9.7	4.7-17.0
FEB 2015	1861	37	20.0	12.2-30.8	635	15	23.6	15.3-34.5	1004	3	2.9	0.6-7.2
MAR 2015	1724	33	19.1	12.2-29.6	615	17	27.6	18.6-39.2	989	6	6.0	2.2-13.0
APR 2015	1787	48	27.0	17.7-39.2	582	15	25.7	16.9-36-9	971	2	2.0	0.2-7.2
MAY 2015	1888	39	20.6	12.9-30.8	553	11	19.8	12.2-29.6	943	7	7.4	3.4-14.4
JUN 2015	1886	55	29.1	20.2-41.6	567	13	23.0	14.5-34.5	945	4	4.2	1.6-10.2
JUL 2015	1897	46	24.2	16.1-35.7	550	16	29.0	19.4-41.6	942	4	4.2	1.6-10.2

Chapter 10: Discussion

This thesis generated previously unavailable evidence regarding Australia's self-harm monitoring and reporting practices among asylum seekers, as well as the episode rates and key characteristics of self-harm, across the entire Australian asylum seeker population. This chapter first provides a summary of these findings, before outlining an interpretation of the main findings and their contribution to the broader literature. The implications of these novel findings for policy and practice are then considered, followed by an outline of key strengths, limitations, and future directions for research in this area.

10.1 Summary of findings

Chapter 2 provided a summary of the main pieces of international and national legislation governing the treatment of asylum seekers who arrived by boat without valid documentation since the introduction of mandatory immigration detention in 1992. Chapter 2 also outlined the main types of onshore immigration detention and community-based arrangements, as well as the five main Australian asylum seeker populations that have existed since the resumption of offshore processing in 2012. As highlighted in Chapter 2, each of these arrangements may exert a number of challenges that may impact on asylum seekers' mental health.

Chapter 3 provided a review of the mental health of asylum seekers, in both detained and community-based settings. The literature reviewed in this chapter indicated that, compared with the general population, asylum seekers experience higher rates of depression, anxiety, and PTSD (see Turrini et al., 2017). Whilst pre-arrival, peri-migration, and post-migration stressors have all been observed to have adverse mental health outcomes for asylum seekers (Fazel et al., 2005; Steel et al., 2009; Turrini et al., 2017; von Werthern et al., 2018), as highlighted in Chapter 3, post-migration stressors may be associated with adverse mental health outcomes over and above the effects of pre-arrival trauma and loss. In Australia, many of these post-migration stressors may be directly linked to government policy, such as

mandatory immigration detention (Coffey et al., 2010; Young & Gordon, 2016). Literature outlined in Chapter 3 indicated that the mental health of detained asylum seekers is adversely affected by conditions and practices associated with both on- and off-shore immigration detention (Green & Eager, 2010; Legal and Constitutional Affairs Reference Committee, 2017; Mares & Jureidini, 2004; Moss, 2015; MSF, 2018; Steel et al., 2006).

Chapter 4 provided a broad overview of self-harm, including common risk factors, motivations, and associated costs. This chapter also outlined what was known about self-harm in asylum seekers prior to this research, as well as the Australian government's self-harm monitoring and reporting processes. Literature reviewed in Chapter 4 indicated that asylum seekers have most of the established risk factors for self-harm – adverse life experiences, socioeconomic disadvantage, mental health disorders, and social isolation (WHO, 2014). Being incarcerated is known to further increase such risk (Franke et al., 2019; Hawton et al., 2013) with detention type or setting (Hawton et al., 2013) and female gender (AIHW, 2013) found to increase risk yet again. Whilst studies pertaining to small sub-sections of the Australian asylum seeker population have reported a high prevalence of self-harm in adult asylum seekers (e.g., Mares & Jureidini, 2004; MSF, 2018; Steel et al., 2004), few studies have examined self-harm across the entire Australian asylum seeker population. Findings from the two extant studies (Dudley, 2003; Hedrick, 2017) examining self-harm across the Australian onshore immigration detention population reported extremely high episode rates of self-harm, particularly in comparison with the general population. Precipitating factors for self-harm in one of these two studies were observed to be largely detention-related and procedure-related factors (Hedrick, 2017). Despite evidence of the detrimental mental health consequences of immigration detention – using self-harm as an index of psychological health – substantial gaps in evidence remain in regards to rates and key characteristics of self-harm across the Australian asylum seeker population. As

highlighted in Chapter 4, such gaps in knowledge exist largely as a consequence of the Australian government's self-harm monitoring and reporting practices (ANAO, 2017; Joint Select Committee on Australia's Immigration Detention Network, 2012; Legal and Constitutional Affairs Reference Committee, 2017). Importantly, these gaps in evidence limit the development of informed self-harm prevention and management strategies, including those at the policy level.

Chapter 5 discussed the methodology and introduced the globally unique self-harm dataset developed for this thesis. This dataset was based on all self-harm incidents reported as occurring among the Australian asylum seeker population between 1 August 2014 and 31 July 2015, obtained via *Freedom of Information*. This was also the largest set of self-harm incident reports ever released from across the entire Australian asylum seeker population, and the first since the resumption of offshore processing. As outlined in Chapter 5, as no comparable data have been released in the interim, this represented a unique opportunity to evaluate the quality of self-harm incident reporting, and to examine the episode rates and key characteristics of self-harm among the Australian asylum seeker population, in order to improve the evidence-based management and prevention of self-harm in asylum seekers.

Chapter 6 provided an evaluation of the quality of self-harm incident reporting across the Australian asylum seeker population, according to WHO (2016) guidelines. Findings reported in Chapter 6 showed that the accessibility and quality of self-harm incident reporting was substandard, when assessed against international guidelines. Basic details (such as date, time of incident, location (processing arrangement), and type of held detention) were routinely reported in 100% of all self-harm incidents. Method(s) used to self-harm were reported in over three quarters of all incidents, however ICD-10 codes were not reported in any incidents (0%). Reporting on gender was found to be particularly poor, recorded in less than two-thirds of all incidents (62%), as were records of psychological assessments (noted after 4% of all

incidents). The findings reported in Chapter 6 demonstrate a clear need to improve self-harm monitoring and reporting practices across the Australian asylum seeker population, including by processing arrangements, in order to better mitigate and respond to self-harm risk, as well as to identify effective self-harm prevention measures.

Chapter 7 examined the episode rates and characteristics of self-harm (such as method(s) used to self-harm) across the Australian asylum seeker population, including by processing arrangements. Calculated self-harm episode rates among asylum seekers in Nauru (260 episodes/1000), and in onshore detention (257 episodes/1000) were more than 200 times the Australian community rates for hospital-treated self-harm (1.2 episodes/1000), respectively. Furthermore, calculated rates of self-harm among asylum seekers on Manus Island (54 episodes/1000) were 45 times the hospital-treated rates of self-harm in the Australian community. By comparison, self-harm episode rates among asylum seekers in community-based arrangements (5/1000) and community detention (27/1000) were four and 22 times the Australian community rates for hospital-treated self-harm. The three most common methods of self-harm across the entire Australian asylum seeker population were cutting, self-battery, and attempted hanging, with high rates of hanging observed in both men and women. Overall, the findings reported in Chapter 7 highlight the exceptionally high episode rates of self-harm among detained asylum seekers compared to rates observed in the general population (Pointer, 2015), and among asylum seekers in community-based settings. Such findings point clearly to the deleterious impact of immigration detention on the health of asylum seekers, and warrant urgent attention. Given the lowered risk of self-harm for asylum seekers in community-based settings, compared with held (or closed) detention, the use of detention as an absolute last resort, and for the shortest possible time - as outlined in Chapter 7: Part two - is likely to be a key component in an informed response to this public health matter.

Evidence gleaned from the study reported in Chapter 7 highlighted the elevated risk of self-harm among asylum seekers in Australian onshore immigration detention. Chapter 8 built upon these findings to consider the influence that different types of closed onshore immigration detention facilities (i.e., IDCs, ITAs, and APODs), with their varying levels of security and supports, might have on the incidence of self-harm in this population. Average episode rates of self-harm were highest in ITAs (452 episodes/1000 asylum seekers), followed by APODs (265 episodes/1000 asylum seekers), and IDCs (225 episodes/1000 asylum seekers). The findings reported in Chapter 8 showed that self-harm episode rates across all three main types of closed immigration detention were markedly higher compared with hospital-treated rates of self-harm in the general Australian population (Pointer, 2015). Of particular interest was the finding that average rates were not lower in facilities with lower security features, and purportedly more flexible accommodation arrangements. When taken together, the findings reported in Chapter 8 illustrate the far-reaching detrimental impact that all types of closed onshore immigration detention have on the mental health of asylum seekers, when self-harm is used as a measure of psychological health. Furthermore, they suggest that making immigration detention environments less secure – but still 'closed' – does not reduce self-harm risk in these environments.

Chapter 9 examined the temporal patterns in the frequency and characteristics of self-harm episodes across the Australian asylum seeker population. Diurnal and monthly variations in self-harm episodes and characteristics were observed across the whole population, including by processing arrangements. Self-harm was significantly more likely to occur in August (than other months of the year) among asylum seekers in onshore detention (19%), in January on Manus Island (18%), and in October on Nauru (15%). Compared with all other methods, self-poisoning (by medication) (25%) was significantly more likely to occur between 12:00am and 3:59am, and self-battery (42%) between 8:00am and 11:59am. A series of procedure-

related and detention-related factors were observed to be associated with these temporal variations in self-harm. When taken together, the findings reported in Chapter 9 demonstrate a need for self-harm monitoring practices to be established to more closely track and identify temporal (and other) trends, in order to protect asylum seekers from further harm.

Overall, this thesis found that the accessibility and quality of self-harm incident reporting across the Australian asylum seeker population was substandard, when assessed against international guidelines. Asylum seekers in onshore and offshore immigration detention were at increased risk of self-harm, compared with the general Australian population, and with asylum seekers in community-based settings. Furthermore, asylum seekers in all three main types of onshore immigration detention were at markedly higher risk of self-harm, compared with the general Australian population. Average rates were not lower in facilities with lower security features, suggesting that making immigration detention environments less secure – but still 'closed' – does not mitigate self-harm risk in these environments. Such findings suggest that it is the closed or held aspect of detention that seems to be the factor associated with the elevated rates of self-harm. Temporal dimensions to self-harm were also found to exist, with variations by time of day and month of year observed across processing arrangements. A number of procedure-related and detention-related factors were observed to be associated with these temporal variations in self-harm.

10.2 Interpretation of findings

The previous section of this chapter provided a summary of the findings generated in the production of this thesis. The next section of this chapter provides an interpretation of the key findings, and their contribution to the broader self-harm, asylum seeker, and prison literature.

Self-harm monitoring and reporting

According to the World Health Organization (2014), surveillance of self-harm is an essential element of national self-harm prevention strategies. Furthermore, they assert that improvements in the quality of self-harm data that is routinely collected and reported on by countries will help 'guide and prioritize the best interventions in each context and contribute to an effective… self-harm prevention strategy' (WHO, 2016, p.3). Prevention strategies include those related to public policy. In Australia, a number of parliamentary and independent reports have cited concerns regarding the Department of Immigration's self-harm monitoring and reporting processes, as well as the lack of independent oversight of such practices (ANAO, 2017; Joint Select Committee on Australia's Immigration Detention Network, 2012; Legal and Constitutional Affairs Reference Committee, 2017). The findings reported in Chapter 6 build and extend upon the more general understandings of the Australian immigration authorities' poor self-harm reporting practices. Specifically, they demonstrate that when systematically assessed against international self-harm reporting guidelines, the quality and accessibility of self-harm data from across the entire Australian asylum seeker population is substandard and inconsistent. The WHO (2016) practice guidelines on establishing and maintaining self-harm surveillance systems state that improvement in the quality and availability of self-harm data is likely needed for all countries. The results of the novel assessment of the quality of self-harm incident reporting across the Australian asylum seeker population documented in this thesis not only affirm this statement with respect to Australia's efforts, but they indicate that there is a substantial need for improvement in the country's self-harm monitoring and reporting practices in order to protect asylum seekers from further harm.

Reporting of psychological assessments

The findings outlined in Chapter 6 indicate that psychological assessments were reported as occurring after just 4% percent of all 949 incidents assessed against WHO (2016) guidelines. Despite being consistent with previous research which revealed a low level of compliance with similar guidelines (Bergen & Hawton, 2007; Hickey et al., 2001), the findings reported in this thesis are concerning as they are contrary to both national and international guidelines (National Collaborating Centre for Mental Health, 2004; RANZCP, 2016), which stipulate that such assessments should be provided in 100% of such cases. Indeed, research by Kapur and colleagues (2002) has observed that repetition of self-harm is higher among individuals who have not received a comprehensive psychological assessment compared with those who have. Such findings suggest that a mechanism to ensure that timely psychosocial assessments are provided for all asylum seekers, following every self-harm episode, is urgently warranted. It is possible that the rate of assessments observed in this thesis may have been higher in practice, and that assessments were simply not recorded, or that they occurred after the three-hour reporting period. Regardless of whether this was the case, the reporting practices highlighted in Chapter 6 can still be considered problematic as they would have undermined efforts to evaluate what was needed to effectively respond to episodes of self-harm.

Reporting on gender, and methods of self-harm

Reporting on gender was also found to be substandard, recorded in just over two-thirds of all incidents assessed against WHO (2016) guidelines, as outlined in Chapter 6. As previous research has highlighted that there are gendered dimensions to self-harm, particularly in regards to method(s) used to self-harm (Canner et al., 2016), and among detained populations (Hawton et al., 2013), the inconsistent reporting highlighted in this thesis may therefore have compromised efforts to effectively respond to gendered trends in self-harm among asylum seekers. Furthermore, whilst the WHO (2016) recommends that standardised ICD-10 codes

that may assist in tracking self-harm trends and making comparisons with relevant populations, (e.g., Australian community or prison populations) are recorded following all incidents of self-harm, these were not reported in any incidents assessed in this thesis. The quality of reporting in regards to self-poisoning observed in this thesis was also found to be substandard, with the name and quantity of medication and/or poison ingested either absent or noted on an ad-hoc basis. The reporting practices documented in this thesis are incompatible with WHO (2016) recommendations regarding the implementation of means reduction strategies, and clearly may have serious consequences for the health and safety of asylum seekers. Efforts to better track self-harm trends, as well as improvement in the quality of data collection and reporting, would therefore be valuable to help inform future self-harm prevention interventions in this vulnerable population.

Episode rates of self-harm across the Australian asylum seeker population

This thesis also provides previously unavailable evidence of the burden of self-harm across the entire Australian asylum seeker population, a recognised gap in the national literature. As reported in Chapter 7, calculated episode rates of self-harm across the whole Australian asylum seeker population were found to be elevated in comparison with rates of hospital treated self-harm in the general Australian population (Pointer, 2015). Furthermore, calculated rates of self-harm among detained asylum seekers were observed to be exceptionally high compared with both hospital-treated rates of self-harm in the general Australian community (Pointer, 2015), and among community-based asylum seekers. When taken together, these findings are in line with previous research which has reported a high prevalence of self-harm among smaller sections of the Australian asylum seeker population (Bull et al., 2012; Deans et al., 2013; Mares & Jureidini, 2004; MSF, 2018; Rivas & Bull, 2018; Steel et al., 2004), as well across the onshore detention population (Dudley, 2003; Hedrick, 2017).

Episode rates of self-harm in detained asylum seekers

The current findings also build and extend upon the aforementioned research by highlighting that the risk of self-harm is elevated across the whole Australian asylum seeker population, though particularly for detained asylum seekers. This pattern is consistent with research from the prison literature which has indicated that rates of self-harm are higher in detained populations than in community populations (Franke et al., 2019; Hawton et al., 2013; Moller et al., 2007). The evidence generated in this thesis regarding the elevated risk of self-harm among detained asylum seekers, in comparison with both the general Australian community (Pointer, 2015), and community-based asylum seekers, is, however, novel from both a national and international perspective. Whilst the adverse mental health consequences of immigration detention have been well-established across a number of studies and for several decades (AHRC, 2014; Coffey et al., 2010; Green & Eager, 2010; Mares & Jureidini, 2004; Steel et al., 2006; Young & Gordon, 2016; von Werthern et al., 2018), the findings reported in this thesis allow us to further discern the mental health consequences of immigration detention – *specifically when using self-harm as an index of psychological health* – at a population level. Importantly, the increased risk of self-harm among detained asylum seekers, compared with those in community-based settings, first observed in this thesis raises a number of pressing questions in relation to necessary changes to policy and practice in the future, such as the expansion of community options for processing (AHRC, 2016; RCOA, 2020a). Indeed, given the increased risk of self-harm for detained asylum seekers identified in this thesis, the exclusion of many asylum seekers from community-based models of processing can be interpreted as an avoidable barrier to improving the mental and physical health of asylum seekers.

Episode rates of self-harm in onshore immigration detention

The findings reported in Chapter 8 build upon those reported in Chapter 7 (taken from across the whole Australian asylum seeker population), by highlighting that calculated episode rates of self-harm were elevated among asylum seekers in all three main types of onshore detention, in comparison with hospital-treated rates of self-harm in the Australian population (Pointer, 2015). What these findings indicate is that asylum seekers in all forms of closed onshore immigration detention are at greater risk of self-harm, compared with the general Australian community. Interestingly, average rates were not observed to be lower in detention facilities with lower levels of security, or purportedly more flexible accommodation, namely ITAs and APODs (AHRC, 2016) in this study - the only extant investigation into the differential impact of closed detention type on self-harm among asylum seekers. Indeed, it might be expected that self-harm episode rates would be lower under such circumstances. Although unexpected, such findings are consistent with research from the prison literature which has observed that rates of self-harm are higher in mixed detention facilities (Hawton et al., 2013), as well as in transit or remand centres (where transfers to and from other settings may occur frequently) (Hawton et al., 2013; Prisons and Probation Ombudsman, 2014), or when length of detention is indeterminate or uncertain (Hawton et al., 2013), features and practices common to both ITAs and APODs. The findings are, however, inconsistent with research from the prison literature which has found that self-harm rates are elevated (particularly for men) in higher security facilities (Hawton, et al., 2013). The underlying gender composition of those detained during the study period may have influenced the pattern observed in this thesis, although improved reporting practices on gender would be needed to test this proposition in future.

When taken together, the novel findings reported in Chapter 8 suggest that making detention facilities less ‘secure’ and prison-like does not minimise self-harm risk in these

environments. Rather, they indicate that it is the closed aspect of detention that is associated with the elevated rates of self-harm observed among asylum seekers in this thesis. Accordingly, informed efforts to reduce self-harm among detained asylum seekers should not necessarily focus on the use of lower security, but still 'closed' facilities, but instead on expanding community options for processing of refugee claims. As highlighted above, community-based options allow asylum seekers to live in homes in the community, including under supervision, whilst their claims for protection are being processed. Such arrangements increase access to social, familial, mental, and physical health supports, all known protective factors for self-harm (Hedrick & Borschmann, 2020a), meaning that expanding access to community options for processing of refugee claims is an intervention that would likely help to protect asylum seekers from further avoidable harm (Hedrick & Borschmann, 2020b).

Methods of self-harm

The findings reported in this thesis also provide previously unavailable evidence regarding differences in methods used to self-harm between detained and community-based asylum seekers, as well as in comparison with the general Australian population, and across genders. As outlined in Chapter 7 cutting, self-battery, and attempted hanging were the three most common methods of self-harm used across the entire asylum seeker population. These three most frequently reported methods of self-harm are consistent with those identified in one of the two previous studies examining self-harm across the onshore detention network (see Hedrick, 2017). Whilst high rates of attempted hanging were also found in this previous study, poor reporting on gender on behalf of the immigration authorities meant that meaningful comparisons between genders were difficult to make. The trend in the high rates of hanging among both male and female asylum seekers now observed in this thesis – and thus unique among the extant literature - is inconsistent with patterns reported in the general community (Pointer, 2015), and warrants urgent attention, as highlighted further below.

Methods of self-harm by gender

In this thesis, asylum seekers of both genders were found to be using more violent and potentially lethal methods of self-harm, than the general population (Pointer, 2015). Such a pattern is inconsistent with what has previously been reported regarding gendered dimensions to self-harm – that while women may be over-represented in self-harm episodes, particularly in detention settings (AIHW, 2013; Hawton et al., 2013), males tend to use more violent and potentially lethal means (Canner et al., 2016). One such interpretation of the high rates of attempted hanging observed among both men and women in this thesis is that this could conceivably relate to the cultural backgrounds of those in the Australian asylum seeker population during the 12-month period. Previous research has, in fact, found that gendered differences in self-harm may vary according to country of origin (Goosen et al., 2011; Sundvall et al., 2015). It was not possible to ascertain whether self-harm methods varied according to cultural background and gender in this thesis, however, as information regarding country of origin was not recorded in the self-harm incident reports. The findings of the current research highlight, therefore, that improved self-harm reporting practices are needed in order to better understand and respond to the gendered and cultural dimensions of self-harm risk among asylum seekers in future.

Attempted hanging among detained asylum seekers

Concerningly, episode rates of attempted hanging reported in this thesis were observed to be significantly higher among asylum seekers in held detention, compared with those in community-based settings, as reported in Chapter 7. Additional evidence that approximately one in ten self-harm incidents in each of the three main types of closed onshore immigration detention involved attempted hanging was highlighted in Chapter 8. As research has established that hanging is strongly associated with an elevated risk of suicide (Hawton et al., 2015; Owens et al. 2002; Skegg, 2005), the high rates of hanging – observed across all forms

of closed immigration detention, all three main types of onshore detention, and among both men and women in this thesis – have serious implications for the safety of asylum seekers across the entire Australian immigration detention population. Indeed, this concerning and previously unavailable evidence points to the urgent need for increased investment in prevention, particularly in regards to re-evaluating Australia's policy of mandatory immigration detention, with its stated objective of being 'administrative not punitive' (Australian Border Force, 2020, p.1). As research also indicates that mental health deteriorates with length of detention (Green & Eagar, 2010), a re-evaluation of this policy would seem critical for preventing outcomes related to poor mental health, including self-harm and suicide. At a minimum, the increased risk of serious harm for detained asylum seekers, as highlighted by these findings, underscores the importance of extending national self-harm prevention strategies (Suicide Prevention Australia, 2019) to the Australian asylum seeker population.

Methods of self-harm among detained asylum seekers

Detained asylum seekers were also found to use a greater range of self-harm methods, compared with community-based asylum seekers, as reported in Chapter 7. Whilst asylum seekers in community-based settings used a range of more traditional methods of self-harm (for example, self-poisoning by medication, and self-battery), asylum seekers in held detention used a variety of traditional methods, in combination with other less common methods (for example, self-poisoning by chemicals, often involving insect repellent, or ingesting foreign objects). This pattern of findings identified among detained asylum seekers in this thesis is consistent with research which has found that individuals in other detained populations improvise in their choice of self-harm methods, potentially once more traditional means are no longer available to them, and that these means often relate to the environment in which they are held (D'arcy, 2017; Tartaro & Lester, 2010).

Importantly, such findings – unique among the extant literature - further highlight the increased risk of self-harm for asylum seekers in held detention compared with those in community-based settings. Policy-makers should be made aware of the mental and physical health costs of inaction in relation to this elevated level of risk. An upstream approach to self-harm prevention among asylum seekers in closed detention – such as the expansion of established models of community-based processing (AHRC, 2016; RCOA, 2020a), rather than a more downstream approach to prevention, such as means reduction – may be a more effective method of addressing self-harm risk among detained asylum seekers. As research indicates that the harmful effects of detention may be enduring (Coffey et al., 2010) and asylum seekers are known to have pre-existing vulnerabilities due to pre- and peri-migration experiences (Fazel et al., 2005; Steel et al., 2009; Turrini et al., 2017; von Werthern et al., 2018), the provision of targeted mental health support may also help to improve mental health outcomes post-release from detention. Mental health interventions, specifically tailored to meet the needs of asylum seekers, should therefore be provided as a matter of urgency in future.

Temporal dimensions of self-harm

Whilst Chapters 7 and 8 outlined previously unavailable evidence regarding the extent of self-harm among asylum seekers, particularly among detained asylum seekers, as well as by held detention type, Chapter 9 provided novel evidence of the temporal variations in self-harm. Indeed, no research has previously investigated whether self-harm among asylum seekers varies according to time of day, day of the week, and month of the year, and considered the implications this may have for self-harm prevention. Drawing on the three WHO (2016) core data items related to time reported in 100% of all self-harm incidents during the study period, Chapter 9 found significant diurnal and monthly variations in self-harm, according to processing arrangements. A series of procedure-related and detention-

related factors were observed to be associated with these temporal variations in self-harm, as further considered in terms of immigration detention policy, as well as the broader literature, below.

Self-harm by time of day, according to processing arrangements

In regards to the diurnal variations observed, the early morning peak (between 12:00am and 3:59am) in self-harm identified in this thesis among community-based asylum seekers is consistent with the late evening to early morning patterns found in hospital-treated self-harm presentation (Blekiron et al., 2000). Importantly, the early morning peak in self-harm found in community-based asylum seekers highlights the disrupted sleep-wake cycles of this population. This is likely a consequence of mental health conditions such as depression and/or anxiety, precipitated by the circumstances under which community-based asylum seekers are living, as highlighted in more detail in section **10.3 – Implications for policy and practice**. It also conceivable that the disrupted sleep wake cycles are potentially more evident in community-based asylum seekers, as their evening routines are less able to be controlled than in other populations. Indeed, it is worth highlighting that self-harm by self-poisoning (involving medication) was significantly more likely to occur during this same four-hourly time interval (i.e., between 12:00am and 3:59am). This finding might point to the greater access to medication, and lower levels of supervision, that community-based asylum seekers have in comparison to those in held detention. Importantly, such novel evidence – first generated in the production of this thesis - has implications for both policy changes (in terms of increased mental and social support for community-based asylum seekers), as well as means reduction strategies, as outlined further below.

The early evening peak (4pm-7pm) in self-harm observed among asylum seekers on Manus Island in this thesis is consistent with recent findings from the prison literature (Irish Prison

Service, 2018). Such research found that self-harm during a similar time of the day was associated with a range of detention-related and procedure-related factors, including staffing and security changes. As service provision and staffing levels have previously been identified as being substandard on Manus Island (ANAO, 2017), it is plausible that the time of day in which access to physical, mental, and other support services becomes limited corresponds to an increase in self-harm for asylum seekers held there. Furthermore, as threats to asylum seekers' safety, including acts of violence and intimidation by locals and security personnel, have also been reported as occurring on several occasions on Manus Island (Amnesty International, 2014), it is also conceivable that as the evening approaches asylum seekers' distress and fear may intensify, thereby triggering episodes of self-harm.

For asylum seekers in onshore detention, there are a range of possible explanations worth considering for the observed pattern of self-harm (between 8pm-midnight): the state of the centres at this time of the evening (AHRC, 2014; Essex & Govintharajah, 2017), fear of transfer during the night (AHRC, 2014; Hedrick, 2017) and lower levels of supervision than at other times of the day. When taken together, the findings documented in this thesis from across various processing arrangements suggest that practices and conditions that increase asylum seekers' vulnerability may be associated with the rates of self-harm observed in this thesis. Whilst future research may be needed to more directly investigate such links, the novel findings reported in this thesis suggest that use of detention as a last resort, in conjunction with the expansion of (enhanced) community models for processing, are key components in addressing the elevated risk of self-harm among asylum seekers.

Self-harm by month of occurrence, according to processing arrangements

Distinct monthly variations in self-harm were also found according to processing arrangements, as reported in Chapter 9, with self-harm significantly more likely to occur in August (2014) than other months of the year among asylum seekers in onshore detention, in

January (2015) on Manus Island, and in October (2014) in Nauru. A series of procedure-related and detention-related factors were also observed to be associated with these monthly variations in self-harm. For asylum seekers in Nauru, any remaining hope about applying for an Australian visa, for example, was closed by an announcement by the Minister for Immigration in September 2014; also at this time the Minister indicated that asylum seekers in Nauru may be resettled in Cambodia (Department of Foreign Affairs and Trade, 2014; New Matilda, 2014). Several allegations of sexual and physical abuse against women and children detained on Nauru were also made in mid-September to early October 2014, prompting the announcement of a government investigation on 3 October 2014, which later became the Moss (2015) review.

For asylum seekers detained on Manus Island, unrest reported to have occurred throughout January 2015 (Davidson & Doherty, 2015; Evershed & Doherty, 2015), almost certainly contributed to increased distress and self-harm observed during this time. According to reports from human rights organisations, asylum seekers who had been determined to be refugees were fearful they would be placed at greater risk of attacks by locals after being told they were to be moved to insecure accommodation on 22 January 2015 (Evershed & Doherty, 2015). Unrest involving up to 300 asylum seekers was then reported as occurring over several days, with numbers of asylum seekers on a hunger strike eventually reaching over 500 and continuing for more than 10 days (Evershed & Doherty, 2015).When taken together, these findings highlighting the monthly variations in self-harm by processing arrangements suggest that specific policies, practices, and conditions in immigration detention are likely to be associated with the elevated rates of self-harm observed in this thesis. Importantly, they demonstrate that there is a clear and pressing need to consider alternatives to the use of immigration detention, in order to prevent poor mental health outcomes in asylum seekers. Indeed, given the increased risk of self-harm among detained asylum seekers - first

documented in the production of this thesis - such changes to immigration policy should be implemented as a public health priority.

10.3 Implications for policy and practice

The previous section of this chapter provided an interpretation of the key findings of this thesis and their contribution to the broader literature. The next section of this chapter outlines the implications of these findings for policy and practice. As stated above, this thesis provided the first available evidence that the quality and accessibility of self-harm incident reporting across the Australian asylum seeker population was substandard, when assessed against international guidelines. In addition, this thesis provided the first evidence that asylum seekers in both on and offshore detention were at increased risk of self-harm, compared with the general Australian population, and with community-based asylum seekers. Furthermore, asylum seekers in all three types of closed onshore detention were found to be at higher risk of self-harm than the general Australian population. Average rates were not observed to be lower in facilities with lower security features, providing novel evidence that making detention environments less 'secure' and prison-like, but still 'closed', does not reduce self-harm risk. Importantly, including for the purposes of the next section of this chapter, the findings reported above provide the first available evidence for the need for the policy and practice recommendations proposed further below – *specifically as they apply to self-harm prevention*.

The previously unavailable evidence generated across all four studies in this thesis has a number of implications for both policy and practice. As highlighted below, an evidence-based response to this public health matter should include three main elements: the use of detention only as an absolute last resort and for the shortest possible time; the provision of mental health services targeted to meet the needs of asylum seekers; and the independent monitoring and reporting of self-harm, in accordance with international guidelines. The specific policy

and practice recommendations associated with the three main elements of the evidence-based public health response proposed below can be further broken down into upstream and downstream self-harm prevention strategies. In the public health context, upstream prevention strategies tend to include policy approaches targeted at the population level, with a view to preventing issues from occurring in the first place, whereas downstream strategies may focus on individual-level behaviour or management of an issue, often after it has occurred (Brownson, Seiler & Eyler, 2010). Targeting both of these levels allows for a more comprehensive approach to self-harm prevention and management. Figure 10.1 outlines the key policy and practice recommendations for self-harm prevention arising directly from this body of research, from downstream to upstream.

Figure 10.1. Policy and practice recommendations for self-harm prevention from downstream to upstream.

The use of detention as an absolute last resort

The detrimental mental health consequences of mandatory immigration detention – using self-harm as a measure of psychological health – observed in this thesis warrant urgent attention at a policy level. When taken together, the findings reported indicate that there is a public health opportunity to minimise the risk of self-harm among asylum seekers. Indeed, the use of detention as an absolute last resort and for the shortest possible time – a longstanding UNHCR (1986) position – would seem to be the most informed policy response to this public health matter. In fact, according to the UN Working Group on Arbitrary Detention's [WGAD] revised statement (2018), 'any form of administrative detention or custody must be used as an exceptional measure of last resort, for the shortest possible period and only if justified by a legitimate purpose' (p.2), for example, to enable health, security and identity checks. The maximum period by which asylum seekers can be held must also be enshrined in law (WGAD, 2018). Importantly, there are already well-established models of community processing in Australia (AHRC, 2016; RCOA, 2020a) that could be expanded to incorporate currently detained asylum seekers. These include models where asylum seekers live in the community, under supervision and in a specified location, such as community detention, or community-based arrangements (RCOA 2020a), where asylum seekers may live in a place of their own choosing, and with fewer restrictions.

There is a precedent for such action, as the Australian government has previously expanded the use of community options at times when the detention network has been under strain (Phillips & Spinks, 2013). Additionally, the Minister for Immigration also has the power to grant 'residence determinations' for asylum seekers assessed as having certain vulnerabilities (RCOA, 2020a), which allow them to live in community detention, whilst their claims for protection are being processed. The findings of this thesis clearly show that asylum seekers in closed detention are at substantially higher risk of self-harm, than those living in community-

based arrangements, or in community detention, reflecting a considerable degree of vulnerability. Community-based options could therefore conceivably be expanded to include those currently detained, pending health, security, and character checks, in line with the stated position of both the UNHCR (2020) and the WGAD (2018).

Mental health services for asylum seekers

Any expanded use of community-based processing options must also ensure that adequate mental, physical, and social supports are in place, as well as providing income, housing and food security. Inconsistent or limited access to these types of supports has been found to increase community-based asylum seekers' vulnerability (RCOA, 2018). Given this, improving access to such supports is likely to be critical for improving the mental and physical health outcomes for all community-based asylum seekers.

Mental health services for asylum seekers should provide culturally appropriate interventions, using accredited interpreters where necessary, to address existing psychological concerns, as well as to prevent further psychological and health related issues (RANZCP, 2017). Mental health interventions must take into account the likely interplay of pre-arrival, peri-migration, and post-migration stressors (Porter & Haslam, 2005; Priebe et al., 2016), as well the evidence that post-migration stressors, such as immigration detention and insecure visa status, may be associated with adverse mental health outcomes over and above the effects of pre-arrival trauma and loss (Coffey et al., 2010; Li et al., 2016; Momartin et al., 2006; Steel et al., 2006).

Furthermore, it is essential that any psychological support is provided in ways that are culturally accessible and meaningful for asylum seekers. Whilst a trauma-informed approach (Phoenix Australia, 2019; RANZCP, 2017) may be appropriate for use with some asylum seekers, and for some presentations, for others, psycho-education, coupled with non trauma-

focused techniques (e.g., increasing cognitive control over intrusive or distressing thoughts, distraction or suppression techniques, distress tolerance strategies, or supportive groups) may be more appropriate (Coffey, 2015). In addition, practitioners working directly with self-harm among asylum seekers should explore the cultural meanings and functions of self-harm for individuals, where appropriate, in order to better inform interventions and responses in future. Indeed, common understandings of functions and motivations of self-harm (e.g., Klonsky, 2007) do largely correspond with western paradigms. Few studies have, in fact, directly examined the cultural meanings of self-harm among asylum seekers and refugees (Garguilo, Tessitore, Grottaglie, & Margherita, 2020), likely due to the ethical challenges regarding conducting research with asylum seekers, particularly those who are detained. As highlighted in section **10.4 Strengths, limitations and future directions**, this may limit the development of more culturally appropriate interventions, and should be made a priority for future research. In short, whilst outlining a complete model of mental health services for asylum seekers is clearly beyond the scope of this thesis, the provision of culturally appropriate mental health support, consistent with some of the ideas canvassed here, is likely to be essential for improving the mental health outcomes of asylum seekers in future.

Independent monitoring and reporting of self-harm

Expanding the use of community-based processing options for asylum seekers will likely take time, political will, and collaboration across sectors (including health, welfare, legal, and education). Given this, and in light of the findings of this thesis, efforts to minimise the use of closed detention should be combined with efforts to improve understandings of, and responses to, self-harm, such as the independent monitoring and reporting of self-harm. This monitoring and reporting must be transparent and carried out by an independent body of clinical experts who have the statutory power to investigate self-harm among asylum seekers in both detained and community-based settings.

In order to assist with care coordination, and to identify prevention measures, including means reduction strategies, self-harm data should be collected using a standardised incident report form, based on the WHO (2016) core (and optional) data items. Systematic data analysis and tracking of self-harm trends should also occur. In accordance with the WHO (2016) self-harm guidelines, the annual self-harm episode rate per 1000 asylum seekers should be calculated for the total Australian asylum seeker population, and disaggregated by gender, processing arrangements, held detention type, and individual facility, based on the average annual adult population figures for the Australian asylum seeker population. Such figures can be sourced from data the Department of Home Affairs (2020) regularly collates on the number of detainees in onshore and offshore immigration detention, as well as those living in community-based settings. The Department of Home Affairs should ensure that these population figures are disaggregated according to the composition of each population (e.g., IMAs, visa overstayers), gender, country of origin, age, and length of detention. In addition to episode rates of self-harm, individual rates of self-harm should also be calculated, including 95% confidence intervals for each of the rates, so that it is possible to differentiate between the number of individuals self-harming and the total number of self-harm incidents. In line with the WHO (2016) guidelines, the analysis and reporting of self-harm rates, trends (such as in method(s) used to self-harm, and the temporal dimensions of self-harm), and any appropriate comparisons (e.g., by gender, held detention type, or other sub-populations) should be carried out on at least a quarterly basis. Tracking of temporal trends in self-harm (by time of day, day of the week, and month of occurrence) should also directly investigate any potential associations with immigration policies, practices, and conditions. The independent body of clinical experts could then utilise these data to prepare reports and provide recommendations, including regarding appropriate interventions, to the Commonwealth Government, the Australian Human Rights Commission, National

Preventative Mechanisms [NPMs] (as designated by the Optional Protocol Against Torture [OPCAT]), the UNHCR, health bodies (e.g., RANZCP), as well as the private service providers (e.g., International Health and Medical Services), contracted to operate within the immigration detention network.

A process to ensure that comprehensive psychosocial assessments are provided for all asylum seekers following every self-harm incident – in line with clinical guidelines - should also be established. The independent statutory body of clinical experts could conceivably play a role in the monitoring of these assessments. Such a process may help to better determine the needs and most appropriate care for asylum seekers, and thereby reduce both self-harm repetition (Kapur et al., 2002), and suicide risk (Hawton et al., 2015; Owens et al. 2002; Skegg, 2005), as previously outlined.

Finally, given the inconsistencies in the quality of self-harm reporting found between processing arrangements, standardised training in self-harm incident reporting must be provided for all staff and contractors across the entire Australian asylum seeker system. Such training should be mandatory, provided at regular intervals, and across every location, and include a component on the relationship between incident reporting and self-harm risk mitigation. All training should be conducted by an independent body, with additional guidance and support made available on a routine basis.

10.4 Strengths, limitations, and future directions

There are a number of strengths of the present work. All four studies in this thesis were generated from the largest set of self-harm incident reports ever made publicly accessible from across the entire Australian asylum seeker population. This globally unique dataset was developed for use in this thesis, using Freedom of Information requests. Importantly, given the lack of accessible data, the studies outlined in Chapters 6-9 were able to draw on all self-harm incidents reported as occurring in the Australian asylum seeker population over a 12-

month period. Furthermore, the sample size was large, meaning that findings pertaining to the entire Australian asylum seeker population (Chapters 6, 7, and 9), the five main processing arrangements (Chapters 6, 7, and 9), as well as the three main types of 'closed' onshore immigration detention (Chapter 8), and the individual facilities the main detention types were comprised of (Chapter 8), could be generated. Additionally, the characteristics of self-harm, including method(s) used to self-harm (chapters 6, 7, 8, and 9), as well as the site of bodily injury – the first published data of this kind (Chapters 7 and 8) – and the temporal dimensions of self-harm (Chapter 9), were able to be examined. As highlighted in Chapter 5, no further self-harm data have been released by the government or under FOI laws in the intervening period. This means that the data utilised in this thesis remain the largest, and the only currently accessible self-harm dataset from across the entire Australian asylum population.

Methodological limitations

This thesis also had several methodological limitations. The number of unreported self-harm incidents over the study period is not known. As most self-harm is not followed by help-seeking behaviour (Nada-Raja, Morrison, & Skegg, 2003), it is highly plausible that the number of self-harm episodes reported represents an under-estimate of the true incidence of self-harm occurring across the Australian asylum seeker population. Moreover, inquiries and independent reviews into immigration detention have identified a number of inconsistencies with incident reporting practices, including cases where incident reports have been destroyed (ALA, 2016; ANAO, 2017; Legal and Constitutional Affairs Reference Committee, 2017). As some of the data I sought to extract from the self-harm incident reports were not routinely reported, or required to be reported by the DIBP, the amount of data that I was able to collect was also limited. Information relating to gender, for example, could only be extracted from just over two-thirds of the self-harm incident reports, meaning that some processing arrangements had higher proportions of missing gender data than other processing

arrangements. This limited my ability to calculate reliable male and female self-harm rates, including by processing arrangements, held detention type, and at the individual facility level (Chapters 7 and 8), to investigate gendered dimensions associated with method(s) used to self-harm (Chapters 7 and 8), as well as to reliably investigate any interactions between gender and temporal dimensions (Chapter 9). Future investigations into the gendered dimensions of self-harm, alongside improved reporting practices, are urgently needed to better understand and respond to these components of self-harm risk among asylum seekers. Furthermore, whilst mental health among asylum seekers in Australian immigration detention has previously been to found deteriorate with length of detention (Green & Eagar, 2010), information regarding time spent in detention was not recorded on the incident reports. Identifying information such as country of origin and age, which have been observed to be associated with self-harm, including method(s) used to self-harm (Goosen et al., 2011; Sundvall et al., 2015; WHO, 2014), would also have been redacted prior to the incident reports being released under FOI. In Chapters 6-9, I sought to address the lack of country of origin information by instead sourcing these details (by processing arrangements only, and not by held detention type, or individual facility) from official DIBP (2015) statistics, as well as figures referenced by the RCOA (2015). Information relating to precipitating factors for self-harm was also only able to be extracted from less than ten percent of all self-harm incident reports, meaning I was not able to reliably investigate precipitants for self-harm across the asylum seeker population. In addition to this, information regarding psychiatric history and suicidal intent – which have previously been found to be associated with self-harm in the general population (WHO, 2014) – was not able to be extracted from the self-harm incident reports. Additional research into the key characteristics of self-harm, particularly country of origin, age, and length of detention, in concert with better self-harm

data collection, would be valuable for informing future responses to self-harm prevention and management among asylum seekers.

The data analysed also did not include instances of suicide, as deaths are not recorded in this category of incident reports. As outlined in Chapters 6, 8, and 9, there were three deaths by suicide during the study period (Australian Border Deaths Database, 2020). Whilst these deaths may speak to neglect and/or other forms of structural abuse, and are clearly of concern, the inclusion of these reported suicides would not have made a difference to patterns in the self-harm data. Nor given the numbers would patterns have been discernible.

In Chapter 9 – an examination of the temporal dimensions of self-harm – there was also the potential risk of making a Type 1 error, given the number of exploratory comparisons undertaken: this risk was minimised by lowering the significance threshold from 0.05 to 0.01 (Bryman, 2016). The low numbers of self-harm observations meant that it was not possible to detect statistically significance differences in self-harm among asylum seekers in community detention by month of occurrence. The implications of this were that it was not possible to ascertain whether self-harm among asylum seekers in community detention varied by month of the year, or make meaningful comparisons regarding monthly variations in self-harm across all processing arrangements. Furthermore, it was difficult to draw firm conclusions about the impact of time of year given there were only 12 months' worth of data. It was also not feasible in this study to directly investigate any potential links with immigration policies, practices, and conditions. Targeted investigations into these temporal trends would be likely to provide valuable information that may be used to inform future self-harm interventions among asylum seekers, particularly at a policy level.

Whilst conducting research with asylum seekers, especially those held in immigration detention, is challenging for a number of ethical reasons, future research into self-harm among asylum seekers must include the experiences and perspectives of asylum seekers

themselves. Mixed methods investigations that explore the cultural meanings and functions of self-harm are urgently needed to better inform understandings of, and responses to, self-harm among asylum seekers.

10.5 Summary

This thesis included four studies which generated novel evidence of Australia's substandard and inconsistent self-harm monitoring and reporting practices among asylum seekers; the substantial burden of self-harm across the Australian asylum seeker population, particularly among detained asylum seekers, and in comparison with the general Australian population; the markedly high episode rates of self-harm across all three main types of onshore detention, where average rates were not lower in facilities with lower security features; and the variations in self-harm according to time of day and month of the year, including by processing arrangements. Furthermore, high rates of attempted hanging were observed among those in held immigration detention, compared with community-based settings, as well as in all three main types of onshore detention, and in both males and females. When taken together, the findings across the studies included in this thesis make a compelling argument for the expansion of community-based models for processing; targeted, culturally appropriate mental health services for asylum seekers; and the concurrent implementation of independent monitoring and reporting of self-harm by a body of clinical experts who have the statutory power to investigate self-harm among asylum seekers. Given the harms observed, informed responses such as these may prove pivotal for reducing levels of distress, and improving mental health outcomes across the Australian asylum seeker population.

10.6 References

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