

The mental health of immigrant and refugee children and adolescents

A case of public policy confusion

IN RECENT YEARS, there has been an increasing focus on the mental health of children and adolescents.¹ This is part of the broader process of reform of Australian mental health services, which now emphasises mental health promotion, the development of preventive approaches, early detection of mental disorders and early treatment interventions.² At the same time, there is now clearer recognition that, in a country as culturally and linguistically diverse as Australia, specific attention must be paid to the cultural dimensions of mental disorder and mental health service design and the specific needs of Indigenous people, immigrants and refugees.³ Major national mental health policy statements now recognise these issues, and funding for State-based transcultural mental health units and centres for the treatment and support of torture and trauma survivors is one aspect of implementing this policy.

This is consistent with increased attention being paid to the mental health of immigrants and refugees internationally.⁴ Of the 6.1 million refugees worldwide for whom demographic data are available, 45.6% are aged under 18 years, although the proportion of children and adolescents varies considerably by region (eg, 56% of refugees in Africa, 23% of refugees in Europe).⁵ In 2001 there were 900 000 asylum applications pending worldwide.⁵

The article by McKelvey and colleagues⁶ in this issue of the Journal (*page 410*) is important for several reasons. Firstly, research data on the mental health of immigrant and refugee children and adolescents are scarce. The study contributes to knowledge about one of the largest immigrant/refugee communities in Australia in a way that cannot be achieved even by large-scale and expensive studies that aim to be representative of the Australian population.^{1,7} The recent national survey of 4500 children and adolescents "provides only very limited information about the mental health of children and adolescents living in non-English speaking families".¹

Secondly, the authors carefully avoided methodological pitfalls commonly seen in cross-cultural mental health research. They used appropriate translation methods for the questionnaire, worked in partnership with community leaders and Vietnamese-speaking mental health professionals, and conducted research interviews in either English or Vietnamese, using bilingual research staff who were trained and supervised in interview administration. Such attention to appropriate cross-cultural research methods is essential to ensure the validity of information obtained.

Thirdly, the study is important because of the finding that the prevalence of psychiatric disorders in Vietnamese children and adolescents was not significantly different from that found in a general Western Australian sample⁸ and in a national sample,¹ despite the fact that many of these chil-

dren and adolescents had been affected by the stresses of migration to a vastly different cultural environment and that many came from families who had lived through the traumas of war.

The data of McKelvey and colleagues relate to Vietnamese refugees settling in Western Australia at one point in time. The same rigorous research process is highly desirable when comparing other refugee populations, especially those experiencing different traumas before migration or different experiences of settlement within Australia. A clinical challenge is to identify subgroups who have suffered, or are at risk of developing, adverse psychiatric consequences. In the study by McKelvey et al, the low rates of mental health problems identified by parents highlights but one of the difficulties that young people from migrant families have in accessing mental health services.

There may be a range of explanations for the relatively low rate of mental disorders identified in the study. However, if corroborated by studies of other ethnic groups and research in other settings, these data may reflect a feature of Australian society that has been a considerable success. That is, our capacity to accept immigrants and refugees from all over the world; to integrate new arrivals into a generally harmonious and well-functioning multicultural society; to create the conditions necessary for refugees to recover from trauma; and to provide an environment that is conducive to normal development, especially in children and adolescents. Underpinning this success have been legal and policy frameworks for multiculturalism, extensive services that have supported the successful permanent settlement of immigrants and refugees, and the general goodwill shown by the Australian population to immigrants and refugees.

Unfortunately, recent years have seen a substantial bipartisan policy shift in Australia's treatment of asylum seekers, particularly of people arriving unauthorised by boat.⁹ The policy of mandatory detention of unauthorised "boat people" is now the subject of heated debate. One component of the debate has been the question of whether prolonged detention has harmful effects on the mental health of detainees in general,¹⁰ and on the mental health and development of children and adolescents in particular.¹¹ On this latter issue, the subject of an inquiry by the Human Rights and Equal Opportunity Commission, there is remarkable unanimity of medical opinion: prolonged detention *is* causing harm to the mental health and development of children and adolescents.¹²

Also of concern is the plight of refugees who have been granted temporary protection visas and live within the community. In comparison with refugees who have obtained permanent residency visas, these people have substantially restricted rights, including the preclusion of family reunion

*... attention to appropriate
cross-cultural research methods
is essential ...*

and limited access to social services, English-language training and other services. There is concern that such restrictions may contribute to mental health problems in this group.^{13,14} Children's emotional and social development may be adversely affected if they are living with parents who are functionally impaired because of depression, anxiety or other mental health problems relating to the stresses and uncertainties of being a temporary visa holder.

Current immigration policy, in the form of prolonged detention of asylum seekers and the move to temporary visas for some, is resulting in harm to the mental health of already vulnerable children, adolescents and adults. The mental health impact of this aspect of immigration policy appears at odds with national mental health policy and with the successful settlement policies that still apply to authorised immigrants and some refugees. The study by McKelvey and colleagues⁶ shows that we can do very much better than this.

I Harry Minas

Director, Centre for International Mental Health, School of Population Health University of Melbourne, and Director, Victorian Transcultural Psychiatry Unit St Vincent's Hospital, Melbourne

Susan M Sawyer

Deputy Director, Centre for Adolescent Health, Royal Children's Hospital Parkville and Acting Head, Department of Paediatrics, University of Melbourne sawyers@cryptic.rch.unimelb.edu.au

1. Sawyer MG, Arney FM, Baghurst PA, et al. Mental health of young people in Australia: child and adolescent component of the National Survey of Mental Health and Well-being. Canberra: Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, 2000.
2. Raphael B. Promoting the mental health and wellbeing of children and young people. Discussion paper: key principles and directions. Canberra: National Mental Health Working Group, Department of Health and Aged Care, 2000: 6.
3. Minas IH, Lambert T, Boranga G, Kostov S. Mental health services for immigrants: transforming policy into practice. Canberra: Australian Government Publishing Service, 1996.
4. Kirmayer LJ, Minas H. The future of cultural psychiatry: an international perspective. *Can J Psychiatry* 2000; 45: 438-446.
5. United Nations High Commissioner for Refugees. UNHCR: the UN refugee agency. Available at: <<http://www.unhcr.ch>>. Accessed 2 September 2002.
6. McKelvey RS, Sang DL, Baldassar L, et al. The prevalence of psychiatric disorder among Vietnamese children and adolescents. *Med J Aust* 2002; 177: 410-414.
7. Andrews G, Hall W, Teesson M, Henderson S. The mental health of Australians. Canberra: Commonwealth Department of Health and Aged Care, 1999.
8. Zubrick SR, Silburn SR, Gurrin L, et al. Western Australian Child Health Survey: developing health and well-being in the nineties. Perth: Australian Bureau of Statistics and TVW Telethon Institute for Child Health Research, 1995.
9. Silove D. The asylum debacle in Australia: a challenge for psychiatry. *Aust N Z J Psychiatry* 2002; 36: 290-296.
10. Steel Z, Silove DM. The mental health implications of detaining asylum seekers. *Med J Aust* 2001; 175: 596-599.
11. Mares S, Newman L, Dudley M, Gale F. Seeking refuge, losing hope: parents and children in immigration detention. *Australas Psychiatry* 2002; 10: 91-96.
12. Professional Alliance for the Health of Asylum Seekers and their Children. Submission to the Human Rights and Equal Opportunity Commission. Inquiry into Children in Immigration Detention. May 2002. Available at: <http://www.racp.edu.au/hpu/policy/asylumseekers/alliance_inquiry.pdf>. Accessed 2 September 2002.
13. Smith MM. Asylum seekers in Australia. *Med J Aust* 2001; 175: 587-589.
14. Harris MF, Telfer BL. The health needs of asylum seekers living in the community. *Med J Aust* 2001; 175: 589-592. □

Are Australia's healthcare workers stuck with inadequate needle protection?

The most direct way to reduce percutaneous injuries is to make devices safer

IN THIS ISSUE OF THE JOURNAL, Whitby and McLaws (page 418) provide a thorough epidemiological account of occupational exposure to bloodborne pathogens by hollow-bore needles in one hospital.¹ More studies such as theirs are needed in Australia, where there has been relatively little attention focused on this issue, as indicated by the few references to studies by Australian investigators cited in their article. As an American I find this surprising, because many successful prevention programs introduced in Australia have earned the admiration of public health professionals in other countries. Three examples come to mind: laws requiring seatbelt use and advanced passenger protection in motor vehicles; progressive HIV prevention programs; and programs to prevent ultraviolet light exposure and skin cancer. I am among the admirers of Australia's strong prevention record. In light of these progressive programs, how might one explain the relative neglect in Australia of such a serious occupational risk as bloodborne pathogen exposure?

Some answers may be extrapolated from the United States, where I have observed a culture of self-sacrifice among healthcare professionals that compels them to place self-interest at the bottom of their priority scale. I have also

seen administrators make healthcare worker safety a low priority when protective measures for their employees require a financial commitment. Finally, resistance to new prevention policies for healthcare workers is likely to be strongest where there is a lack of surveillance data. This is the "no data, no problem" syndrome.

In Australia, an awareness of the significance of the problem of exposure to bloodborne pathogens is necessary before a national commitment can be made to its solution. Percutaneous injuries are the most frequent type of injury sustained by healthcare workers, and the most life-threatening.² This remains true despite important advances, including the availability of the hepatitis B vaccine and post-exposure chemoprophylaxis for HIV-exposed healthcare workers.^{3,4} Therefore, I am convinced that the only choice is to accept the responsibility of caring for our caregivers — in Australia and elsewhere.

The first step towards overcoming neglect is documenting the problem. The report by Whitby and McLaws provides a fine example, on a small scale. With reported annual percutaneous injury rates of 4–15 injuries per 100 full-time-equivalent staff,¹ and device-specific injury rates occurring usually in the range of 1–20 injuries per 100 000 devices