A child in detention: dilemmas faced by health professionals

Karen J Zwi, Brenda Herzberg, David Dossetor and Jyotsna Field

A 6-year-old child, held in detention with his parents pending the outcome of their application for refugee status, manifested psychological distress by repeated episodes of refusing to eat or drink. This case presented clinical and ethical dilemmas for health professionals who were constrained from acting in the child's best interests by government policy of mandatory detention.

(MJA 2003; 179: 319-322)

IT IS AUSTRALIAN GOVERNMENT POLICY to detain asylum seekers who do not have a valid entry visa in one of six privately operated immigration detention centres while their refugee status is determined (Box 1). The detention environment has been implicated as a direct contributor to psychological distress, either *de novo* or as a "retraumatising influence".[1] This is reflected in the suicide rate in detention centres, which is conservatively estimated at 3–17 times that in the Australian community.[2]

Justice P N Bhagwati, Regional Advisor, United Nations High Commission for Human Rights, identified key human rights issues pertaining to immigration detention in Australia.[3] These included the lack of independent monitoring mechanisms, restricted access by healthcare workers and lawyers, lack of protection of the family unit (exemplified in the Woomera Housing Project, whereby women and children were allowed to live in the community while their husbands remained in detention), the policy of detaining unaccompanied minors, and the prison-like conditions, which are not conducive to healthy childhood growth and development.

In August 2001, Australasian paediatricians and psychiatrists issued a joint position statement calling for children and their families to be released from Australian detention centres, and highlighting concern for children's "subsequent emotional development and for the effects of detention on the functioning of their families". In June 2003, there were 315 children held in detention in Australia and Australia's "excised offshore places" (such as Ashmore and Christmas islands),[4] as well as on Manus Island (Papua New Guinea) and Nauru.[5]

The clinical and ethical dilemmas that arise when government policy restricts clinicians' decision-making are illustrated by the clinical record of a 6-year-old boy in detention with his family, who had repeated episodes of refusal to eat or drink (Box 2, page 320). This case highlights issues applicable to many children in detention in Australia.

Department of Psychological Medicine, Children's Hospital at Westmead, Sydney, NSW.

Karen J Zwi, FRACP, Fellow in Child Psychiatry; currently Lecturer (Paediatrics), University of New South Wales and Sydney Children's Hospital; **Brenda Herzberg,** FRANZCP, Child Psychiatrist; currently Staff Specialist, Prince of Wales Hospital; **David Dossetor,** FRCPsych, Child Psychiatrist.

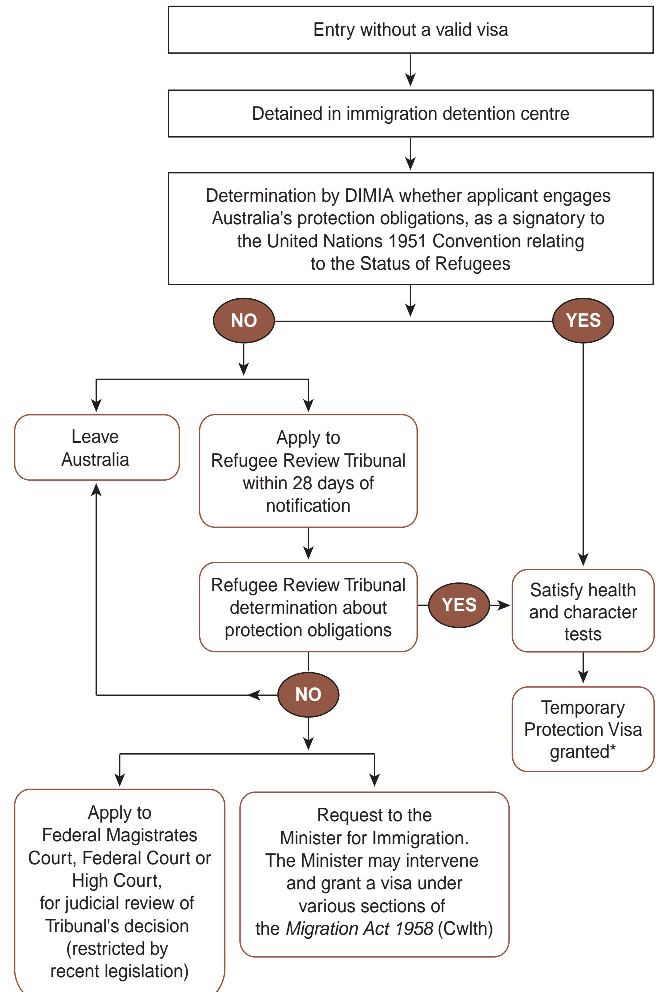
Sydney, NSW.

Jyotsna Field, MPsych, Private Psychotherapist.

Reprints will not be available from the authors. Correspondence: Dr Karen J Zwi, University of New South Wales, School of Women's and Children's Health, Sydney Children's Hospital, High Street, Randwick, NSW 2031. Zwik@sesahs.nsw.gov.au

The child presented here and his parents have given consent for publication of this article.

1: Schematic representation of the process for asylum seekers without a valid entry visa for obtaining a Temporary Protection Visa*



* Information from Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) website (www.immi.gov.au/facts/index.htm).
A Temporary Protection Visa entitles the holder to: temporary residence for 3 years; limited Welfare and resettlement assistance; access to Medicare benefits; no access to government English lessons; no family reunion; cannot leave and re-enter Australia (www.immi.gov.au/facts/64protection.htm).

2: Clinical record — a 6-year-old boy with recurrent refusal to eat or drink

A 6-year-old boy presented to the Emergency Department of the Children's Hospital at Westmead in May 2001. He was accompanied by his mother, infant sister and a uniformed officer from the Villawood Detention Centre. His mother reported, via an interpreter, that he had refused to talk or eat for the last 4 days, but that she had managed to coerce him to take small amounts of liquid. This episode began after the boy observed a man cutting his wrists (in the boy's words "killing himself") at the detention centre.

The family was of Middle Eastern origin and belonged to a small religious group regarded as heretics in their country of origin. They had arrived in Australia by boat in March 2000, and then spent 11 months at Woomera Detention Centre and almost 3 months at Villawood Detention Centre. The younger child was born in detention. The family had been refused refugee status at all the initial stages of processing (Box 1), and were making a final-resort appeal to the Minister for Immigration and Multicultural and Indigenous Affairs for humanitarian consideration, a process seldom successful. The chronology of events is shown in Box 3.

For 6 months before presentation, the boy had withdrawn from play with other children, and had been drawing similar repetitive images (Box 4). He became startled when he heard two-way radios used by detention centre officers. His mother described a chronic history of bedwetting and nightmares, which began after he witnessed riots and people setting themselves alight at the Woomera Detention Centre. Before this, he had been healthy, with normal development, although he had refused to eat and talk for half a day after one incident at Woomera.

On examination, the boy was pale, listless and had clinical signs of mild dehydration. His height and weight were on the 75th and 50th percentiles, respectively. He was admitted to hospital for 6 days during which he gradually resumed talking and eating, although his bedwetting and nightmares persisted. Mental-state examination revealed a dull affect with slow, quiet speech and an anxious penetrating stare. He was unable to verbalise any wishes for the future, and said there was no point in making friends, because they all left while he remained in the "camp". He described bad dreams about officers taking his father to gaol, and people cutting children with glass. The only drawing he produced in which the figures were not covered with bars was one of "the man who cut himself" (Box 5). He displayed extreme separation anxiety when his father departed after visits.

He was assessed by the child psychiatry team as having acute on chronic post-traumatic stress disorder, fulfilling the *Diagnostic and statistical manual of mental disorders* (DSM-IV) criteria[6] in that: (i) he was exposed to traumatic events; (ii) his response involved intense fear and helplessness; (iii) he had persistent re-experiencing of his trauma (through nightmares and with various triggers); (iv) he had a numbing of general responsiveness (with social withdrawal and refusal to speak or eat); and (v) he had symptoms of increased arousal (resulting in disturbed sleep).

The differential diagnosis included depression, but this was considered less likely when many of his symptoms resolved within his short admission.

He was discharged back to the detention centre after 6 days in hospital, with follow-up arranged with the centre psychologist and hospital team. The discharge summary, copied to the Centre Manager of Villawood Detention Centre, stated that he was at high risk of recurrence unless a more normal environment could be provided, that he should remain together with his family, and that access to a school with stable peer relationships would be important.

In addition, it was asserted that the uncertainty about his family's future was likely to be perpetuating his symptoms.

Six days later, the boy re-presented to the hospital with refusal to eat or drink and mild dehydration. His readmission necessitated a series of complex interagency negotiations in an attempt to provide a reasonable standard of care. The negotiations involved Australasian Correctional Management (the agency managing the detention centres), Villawood Detention Centre management and health services teams, and various case managers assigned by the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA), and covered coordinating parental visits and family counselling sessions, interpreters, visitors, culturally appropriate food, and possible discharge arrangements. Other difficulties included the lack of a structured daily program (as an asylum seeker, he was not eligible to attend the hospital [Department of Education] school), the social alienation of the child and family within the ward, the emotional distress experienced by the interpreters encountering the family situation, and dealing with the dilemma of whether the hospital should be acting as a place of safety for the child. Since protection from trauma was the most important part of treatment, discharge to the detention centre was likely to re-traumatise him.

During the 8-week hospital stay, the boy became increasingly frustrated and difficult to contain because of his limited access to recreational, educational and other stimulating activities. He resented that detention centre officers were in close proximity at all times. His separation anxiety was fuelled by unpredictable parental visits, and the alternating arrangement of one parent staying with him. Multiple case planning meetings involving Villawood and DIMIA representatives failed to produce a resolution to the dilemma of a discharge placement for the child. The municipal office of the Department of Community Services was unable to intervene. There was no alternative except to discharge him back to the detention centre.

The child now entered a phase of repeated presentations to the emergency department every few days over a period of 4 weeks, with a pattern of food refusal and dehydration. On each occasion, he required nasogastric rehydration and stayed for 1–2 days. His mother described how he would become pale, quiet and sweaty when he saw the fences that featured in his drawings. After six such presentations, he was readmitted for nutritional review as he had lost 3 kg. Two weeks later, his parents agreed to DIMIA's offer of discharge to foster carers, and DIMIA arranged Department of Community Services approval of the nominated carer.

DIMIA declared the boy's new home and school a "place of detention", and engaged a private psychotherapist. He was reported to have frequent emotional outbursts, disrupted sleep and difficulty coping with separations from his family after weekend access. The foster carers were ill-prepared for dealing with his distress, and the placement was continuously under threat.

With no placement alternative, DIMIA granted permission for the boy to live with his mother and sister in the community. Seven months later, his father joined them when the Federal Court allowed re-application to the Refugee Review Tribunal and Temporary Protection Visas were granted. Of interest is that no new evidence was presented, compared with the family's original application. These visas are valid for 3 years, and the future thereafter is uncertain for the family.

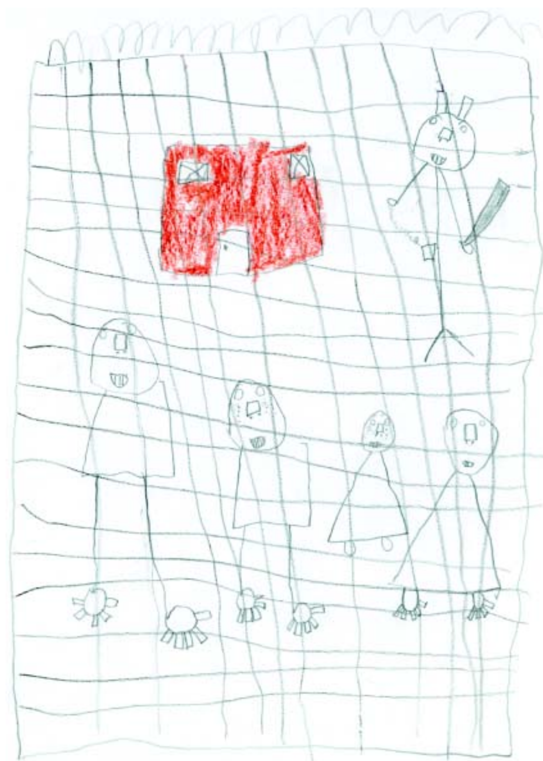
Although an eager learner at school, the boy currently has regular nightmares and is fearful that his family may be returned to the "camp". At the time of publication, the family are being seen by therapists at a state-funded trauma counselling service.

3: Chronology of events related to the child

March 2000	Arrived in Australia (age 5 years)
March 2000 – February 2001	Woomera Detention Centre. Infant sister born
March – May 2001	Villawood Detention Centre
May 2001	Initial hospital presentation and admission (age 6 years)
May 2001	Re-presented 6 days after discharge
May 2001	First letter and fax to the Minister for Immigration from treating team at Children's Hospital at Westmead
May – July 2001	8-week hospital admission
June 2001	Subsequent letter to the Minister for Immigration from treating team at Children's Hospital at Westmead
July – August 2001	Six emergency department presentations
August 2001	Received reply from the Minister for Immigration
September 2001	2-week hospital admission
September 2001	Granted Bridging Visa.* Discharged into foster care
January 2002	Mother and sister granted Bridging Visas, and child returned to mother's care in the community (aged 7 years)
August 2002	Family granted Temporary Protection Visas, allowing family to live together in the community

*Used to allow an applicant for a substantive visa to remain in the country out of detention while their visa application is being processed.

4: The child's drawings were dominated by the fence



"They're crying. They're all scared. Scared of officers — all of them" (the child's description of the people in the foreground). *"It's a stick. They bash up children with that wood"* (the child's description of the person in the background).

Discussion

This boy was in a state of distress, and preoccupied by imprisonment and the violence he had witnessed, as depicted in his drawings (Box 4). The form of his response may have been influenced by the behaviour of distressed adults (as role models) in Woomera and Villawood Detention Centres who staged hunger strikes. His improvement when away from the detention centre, and rapid deterioration on returning, communicated the impact of an aversive environment.

Several authors have described high levels of depression, anxiety and post-traumatic stress disorder (PTSD) in adult asylum seekers detained in Australia. They have also observed that detention may profoundly undermine the parental role, leaving children with little protection or comfort.[1,7,8] Considerable evidence exists that refugee children themselves are at significant risk of developing psychological disturbance (PTSD, depression, anxiety and sleep disorders),[9] but they frequently present with mixed symptoms, not necessarily fulfilling a single diagnostic category.[10] The likelihood of psychological disturbance increases with the synergistic impact of multiple risk factors, including observing parental helplessness, separation from parents, witnessing or experiencing traumatic events, and the time taken for immigration status to be determined.[11]

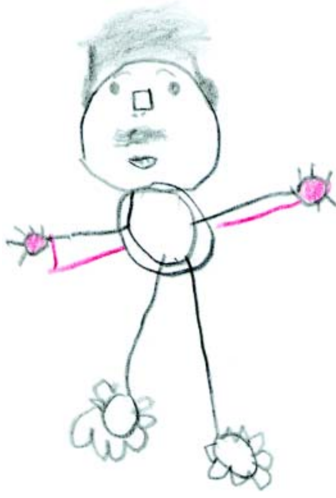
Psychological distress in the early years may have implications for long-term functioning[12,13] and competence in adult life.[14,15] Protective factors for children exposed to trauma include being with their parents,[16] having a safe and predictable environment,[17] and achieving a sense of mastery over the environment by becoming part of a school community.[18,19]

In May 2001, when this child first presented, public and professional criticism of the conditions in detention centres was beginning to be voiced. The treating team studiously avoided media attention, on the assumption that maintaining confidentiality and advocacy at the individual level was likely to produce the most favourable mental health outcome. The team was challenged by differing views on the extent to which healthcare workers should confront the systems issues contributing to this child's distress.

This child's presentation highlighted both a hiatus in the evidence base for effective treatment options for such children, and the frustrations of health professionals at being unable to provide best-practice care. Although we offered play and art therapy, family and individual sessions, "therapy" made little sense, given the boy's awareness of the constant threat of discharge back to the "camp" and the uncertain outcome of the family's refugee claim.

Clinical recommendations, such as maintaining family integrity or school attendance, could not be accommodated by the Department of Immigration and Multicultural and

5: The child's drawing after seeing a detainee cut his wrists



"The man who cut himself"

Indigenous Affairs (DIMIA) and the agency managing the detention centre (Australasian Correctional Management). Child Protection, legal and ethical issues were extensively discussed in managing this case. The overarching constraint was the clash between the principle of acting in the child's best interests and government policy on mandatory detention — often prolonged mandatory detention.

Under the *Children and Young Persons (Care and Protection) Act 1998* (NSW), healthcare workers in New South Wales are mandated to report children at risk of harm to the NSW Department of Community Services, so that appropriate protective measures can be instituted.[20] This child fulfilled the criteria for reporting, and various attempts to report him were made. Child protection is governed by state legislation and could not be activated, as detention centres are a federal responsibility. Furthermore, the Minister for Immigration has certain guardianship rights with respect to asylum-seeker children, creating difficulties for state welfare authorities.

The ethical dilemma of returning a child to an aversive environment is not unusual for health professionals. When the environment is known to be abusive, healthcare workers can call on nominated child-centred agencies to assist in maintaining children's wellbeing. However, this was not possible in this case, as detainee children are not subject to Australian child protection legislation, and their welfare is not systematically monitored.

In 1990, Australia signed the United Nations Convention on the Rights of the Child. This convention embodies the principles of *provision* (of education, health and other services), *protection* (from torture, abuse and arbitrary detention) and *participation* by children in decisions affecting their lives. Article 22 proposes that refugee children should have the same rights as citizen children.[21]

In May 2002, an alliance of health professionals launched a submission to the Human Rights and Equal Opportunity Commission (HREOC) Inquiry into Children in Immigration Detention, and recommended that children should not be held in anything other than minimal detention for processing purposes only, and that all children and their parents should be released immediately.[22] The child presented in this article was the subject of a complaint to the HREOC, which "recommended" that the Australian government pay $70 000 compensation to the child for harm suffered. The government rejected the Commission's findings and recommendations.[23]

Under present government policy, children seeking protection in Australia are unlikely to receive services that fulfil their complex needs, and we remain concerned that their prolonged detention will impair their psychological wellbeing and their capacity to become integrated members of the community.[1]

References

1. Steel Z, Silove DM. The mental health implications of detaining asylum seekers. *Med J Aust* 2001; 175: 596-599.
2. Catholic Commission for Justice, Development and Peace. Damaging kids: children in Department of Immigration and Multicultural and Indigenous Affairs' Immigration Detention Centres. Melbourne: Catholic Commission for Justice, Development and Peace, May 2002. (Occasional Paper No. 12.)
3. Justice P N Bhagwati. Report of the Regional Advisor for Asia and the Pacific of the United Nations High Commissioner for Human Rights: human rights and immigration detention in Australia. Mission to Australia, 24 May – 2 June 2002. Available at: www.chilout.org/files/BhagwatiReportJuly2002.pdf (accessed Aug 2003).
4. Department of Immigration and Multicultural and Indigenous Affairs. Australia's excised offshore places. Available at: www.immi.gov.au/facts/81excised.htm (accessed Aug 2003).
5. Children out of detention. How many children are in detention? Available at: www.chilout.org/ (accessed Jun 2003).
6. American Psychiatric Association. Diagnostic and statistical manual of mental disorders — 4th ed (DSM-IV). Washington, DC: APA, 1994.
7. Mares S, Newman L, Dudley M, Gale F. Seeking refuge, losing hope: parents and children in immigration detention. *Australas Psychiatry* 2002; 10: 91-96.
8. Silove D, Steel Z, Watters C. Policies of deterrence and the mental health of asylum seekers. *JAMA* 2000; 284: 604-611.
9. Saigh PA. The development of posttraumatic stress disorder following four different types of traumatization. *Behav Res Ther* 1991; 29: 213-216.
10. Protacio-Marcelona E. Children of political detainees in the Philippines: sources of stress and coping patterns. *Int J Mental Health* 1989; 18: 71-86.
11. Fazel M, Stein A. The mental health of refugee children. *Arch Dis Child* 2002; 87: 366-370.
12. Perry B. Incubated in terror: neurodevelopmental factors in the "cycle of violence". In: Olefsky JD, editor. Children, youth and violence. The search for solutions. New York: Guildford Press, 1996.
13. McCain MN, Mustard M. Reversing the real brain drain: Early Years Study. Toronto: Ontario Children's Secretariat,1999.
14. Teicher MH, Anderson SL, Polcari A, et al. Developmental neurobiology of childhood stress and trauma. *Psychiatr Clin North Am* 2002; 25: 397-426.
15. Hull AM. Neuroimaging findings in post-traumatic stress disorder. Systematic review. *Br J Psychiatry* 2002; 181: 102-110.
16. Pfefferbaum B. Post traumatic stress disorder in children: a review of the past 10 years. *J Am Acad Child Adolesc Psychiatry* 1997; 36: 1503-1511.
17. Silove D. The psychosocial effects of torture, mass human rights violations and refugee trauma: toward an integrated conceptual framework. *J Nerv Ment Dis* 1999; 187: 200-207.
18. Burnett A, Peel M. Health needs of asylum seekers and refugees. *BMJ* 2001; 322: 544-547.
19. Kinzie JD, Sack W, Angell R, et al. A three-year follow-up of Cambodian young people traumatized as children. *J Am Acad Child Adolesc Psychiatry* 1989; 28: 501-504.
20. Commission for Children and Young People. New South Wales Interagency Guidelines for Child Protection Intervention (2000 edition). Bruce Callaghan and Associates, editors. Sydney: NSW Government, 2000. Available at: www.kids.nsw.gov.au/publications/guidelines/ (accessed Aug 2003).
21. United Nations. United Nations Convention on the Rights of the Child. United Nations General Assembly (Resolution 44/25), 1989. Available at: www.savethechildren.ca/en/whoweare/whounrights.html (accessed Aug 2003).
22. Professional Alliance for the Health of Asylum Seekers and their Children. Submission to the Australian Human Rights and Equal Opportunity Commission (HREOC) Inquiry into Children in Immigration Detention, May 2002. Available at: www.racp.edu.au/hpu/policy/asylumseekers/alliance_inquiry.pdf (accessed Aug 2003).
23. Australian Human Rights and Equal Opportunity Commission (HREOC). Report No. 25. Recommendations. Available at: www.hreoc.gov.au/human_rights/human_rights_reports/hrc_25.html#recom (accessed Aug 2003).

(Received 25 Feb 2003, accepted 13 Aug 2003) ❑