

## Immigration detention and health

Christine B Phillips

*On health grounds, immigration detention should be used in very limited ways*

Like all rich nations, Australia has experienced an increase in people crossing its national borders without the documents authorising them to do so. Since 1992, Australia has had a policy of mandatory detention for these people. About a third of the people in immigration detention are asylum seekers who are requesting sanctuary under the 1951 United Nations Convention Relating to the Status of Refugees, to which Australia was an early signatory. Although some form of immigration detention exists in most developed countries, asylum seekers are generally released into the community after a period of time in detention, while their claims are being processed. Australia pioneered the notion that detention for asylum seekers was a kind of endgame, in which people arriving without authority stayed in detention until they obtained a visa or were deported. Among the Convention signatories, no other nation has followed suit.

As an island nation, our protection obligations are most frequently engaged by asylum seekers arriving by boat. In the financial year 1999–2000, in response to the Taliban insurgency and escalating crises in Iran and Iraq, 4180 asylum seekers arrived by boat.<sup>1</sup> This was more than triple the total number of asylum seekers arriving by boat over the previous 3 years combined. By the following year, Australia's immigration detention centres, many recently opened in remote Australian settings, admitted a total of 11 439 people.<sup>2</sup> In 2000, the mean duration of stay in Australia's immigration detention centres ranged from 1 month to 9 months.<sup>3</sup>

The study by Green and Eagar in this issue of the Journal (page 65) counts the health costs of immigration detention.<sup>4</sup> This is the largest Australian study to date of the health of people who have been in detention, and the first to follow up a cohort over an entire year. Studying the health of such people in the past in Australia has been challenging;<sup>5</sup> previous studies, although valuable, were necessarily small scale.<sup>6–8</sup> In the absence of on-the-ground research, we relied on testimony to a national inquiry by the Australian Human Rights and Equal Opportunity Commission,<sup>9</sup> and the People's Inquiry into Detention.<sup>10</sup> For Green and Eagar's study,<sup>4</sup> a new policy of openness by the Department of Immigration and Citizenship (DIAC) gave the researchers access to databases containing the health records of people who had been in detention.

Their study highlights the contribution of immigration detention to mental illness. Asylum seekers, and other detainees who experienced prolonged detention, were more likely to develop mental illness as a new diagnosis. However, all people who had been in detention for long periods of time had higher attendance rates for a range of health conditions compared with those detained for a shorter time. Sultan and O'Sullivan, in their characterisation of immigration detention syndrome, describe a three-stage process of escalating mental distress and depression, with people in long-term detention being overwhelmed by hopelessness and a sense of being trapped and alone.<sup>6</sup> A follow-up of Mandaeen refugees noted that prolonged immigration detention was associated with the most severe mental disturbance, which continued for an average of 3 years after release from detention.<sup>7</sup> The location of the immigration detention centre where these refugees were held was not stated. The remote onshore detention centres (now all decommissioned) were operating at the time of Green and Eagar's study; the geographical isolation of some of these centres may have also affected detainees' mental health.

The number of children included in Green and Eagar's study was small, as policy changes were made during the study period to limit immigration detention of children. Between 1999 and 2003, over 2000 children arrived without visas, by air or sea, and most spent time in immigration detention (these figures exclude the children in offshore immigration detention centres on Nauru in the Micronesian South Pacific; and Manus Island, Papua New Guinea).<sup>9</sup> Immigration detention centres fostered emotional instability, and children witnessed violence and security crackdowns. The family unit was often too fragile and damaged to provide stability through the vicissitudes of detention life. At the time of writing (23 October 2009), there were 126 children in immigration detention, housed outside the main immigration detention centres.<sup>11</sup> Diligence will be needed to ensure that the residential housing options near immigration detention centres remain supportive of children's development. As pioneers of the practice of long-term immigration detention for children, Australia has a responsibility to collect data on the health outcomes of this social policy.

Internationally, there is now a move to better monitoring of the conditions in immigration detention. In Australia, detention centres in remote locations have been decommissioned, leaving four



in large urban settings, as well as one on Christmas Island. In Australia, the Detention Health Advisory Group provides input into the health services of detention centres, and the DIAC provides more transparency and mechanisms to enhance service quality for immigration detention centres and their health services.

In the United States, where 400 000 people currently enter immigration detention each year, the Department of Homeland Security recently announced the creation of an Office of Detention Policy and Planning to oversee immigration detention. There will also be greater input from a health advisory group.<sup>12</sup>

The openness of the Australian Government to improved oversight mechanisms for detention centres is welcome. Such mechanisms are essential. Immigration issues can inflame public imagination and lead to calls for harsher detention measures for "queue-jumpers". There is a need for the definition of a clinically relevant, immigration detention centre minimum dataset, and for good prospective research to be performed on the health of detainees after their release into the community.

The evidence is growing that asylum seekers are likely to be those most psychologically damaged by immigration detention, and that their children are particularly vulnerable. There is a good case to be made on health grounds that immigration detention should be used in very limited ways for asylum seekers, and never for children.

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