A child in detention: dilemmas faced by health professionals

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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: 000-000)

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”. This is reflected in the suicide rate in detention centres, which is conservatively estimated at 3–17 times that in the Australian community.

Justice P N Bhagwati, Regional Advisor, United Nations High Commission for Human Rights, identified key human rights issues pertaining to immigration detention in Australia. 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), as well as on Manus Island (Papua New Guinea) and Nauru.

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 [facing page]). This case highlights issues applicable to many children in detention in Australia.

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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 on fire 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 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 number 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.
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 functioning12,13 and competence in adult life.14,15 Protective factors for children exposed to trauma include being with their parents,10 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
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. 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 and the same rights as citizen children.21

Article 22 proposes that refugee children should have the best interests and government protection in Australia’s policies of deterrence.20 This child fulfilled the criteria for prolonged detention. He was excised offshore places. Under present government policy, children seeking protection in Australia are unlikely to receive services that fulfill their complex needs, and we remain concerned that their prolonged detention will impair their psychological well-being and their capacity to become integrated members of the community.1

References


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