

Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia

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In 1992, the Australian Federal Government passed legislation enforcing the mandatory detention of all persons arriving in Australia without valid entry documents. Since then, a significant number of asylum seekers and their children have been held in detention for considerable periods of time. By 1998, more than 80 detainees had been held in detention for between two and five years.¹ By 2002, 602 persons continued to be held for longer than 12 months.²

Concerns have been raised repeatedly about the psychological status of persons held in detention by agencies such as the United Nations High Commissioner for Refugees,³ the United Nations Commissioner on Human Rights,⁴ the Australian Human Rights and Equal Opportunity Commission,^{1,5} the Australian Commonwealth Ombudsman,⁶ human rights organisations such as Amnesty International⁷ and

Human Rights Watch,⁸ and medical practitioners.⁹⁻¹⁶ Reports of riots, violence, and hunger strikes appear regularly in the media, with 264 incidents of self-harm among detainees being reported over an eight-month period.¹⁷

Systematic study of the mental health status of detained asylum seekers has been hampered by problems in accessing detainees, an issue prompting expressions of concern by the Australian Medical Association and Combined Medical Colleges.¹⁸ As a consequence, only limited data are available. Thompson and colleagues,¹⁹ in a survey of 25 detained Tamil asylum seekers held at an urban detention centre during 1997 and 1998, found that detainees exhibited high levels of depression, post-traumatic stress, anxiety, panic and physical symptoms compared with expatriate asylum seekers living in the community. Sultan and O'Sullivan,²⁰ in a participant-observation

Abstract

Objective: To document the psychiatric status of a near complete sample of children and their families from one ethnic group held for an extended period of time in a remote immigration detention facility in Australia.

Method: Structured psychiatric interviews were administered by three same-language speaking psychologists by phone to assess the lifetime and current psychiatric disorders among 10 families (14 adults and 20 children) held in immigration detention for more than two years.

Results: All adults and children met diagnostic criteria for at least one current psychiatric disorder with 26 disorders identified among 14 adults, and 52 disorders among 20 children. Retrospective comparisons indicated that adults displayed a threefold and children a tenfold increase in psychiatric disorder subsequent to detention. Exposure to trauma within detention was commonplace. All adults and the majority of children were regularly distressed by sudden and upsetting memories about detention, intrusive images of events that had occurred, and feelings of sadness and hopelessness. The majority of parents felt they were no longer able to care for, support, or control their children.

Conclusions: Detention appears to be injurious to the mental health of asylum seekers.

Implications: The level of exposure to violence and the high level of mental illness identified among detained families provides a warning to policy makers about the potentially damaging effects of prolonged detention on asylum seekers. In their attempt to manage the international asylum crisis, it is important that Western countries do not inadvertently implement policies that cause further harm.

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Table 1: Experiences of adults (n=14) and children (n=19) rated as posing a serious or very serious problem during the time spent within the detention centre environment.

Children ^a	No.	%	Adults	No.	%
Boredom	19	100	Being handcuffed during transport	14	100
Isolation	19	100	Breaches of confidentiality by officers	14	100
Poor- quality food	19	100	Delays in processing refugee application	14	100
Seeing people self-harm	19	100	Denial of adequate food	14	100
Seeing people making suicide attempts	19	100	Exposed to hunger strikes	14	100
Exposed to hunger strikes	18	95	Interviews by immigration officers	14	100
Inappropriate medical care	18	95	No access to recreational activities	14	100
Not allowed to keep food in own room	18	95	Not allowed to make or receive phone calls	14	100
Poor access to counselling	18	95	Poor access to dentistry	14	100
Poor access to dentistry	18	95	Racist comments	14	100
Poor access to emergency medical care	18	95	Being sworn at	13	93
Poor access to long-term medical care	18	95	Fears of being sent home	13	93
Witnessing physical assault	18	95	Inappropriate medical care	13	93
Denial of adequate food	16	84	Not allowed to keep food in own room	13	93
Fears of being sent home	16	84	Threats of physical violence by officers	13	93
No access to recreational activities	16	84	Physical assault by officers	12	86
Worries about lack of medical treatment	15	79	Being told "you should go home"	12	86
Being told "you should go home"	12	63	Woken at night because of head counts	12	86
Woken at night because of head counts	12	63	Over-crowding in rooms	12	86
Delays in processing refugee application	12	63	Personal documents withheld	12	86
Over-crowding in rooms	12	63	Poor access to counselling	12	86
Room searches	12	63	Room searches	12	86
Forced outside for head counts at night	10	53	Officers threatening to influence application	12	86
Being called a number not a name	9	47	Witnessing physical assault	12	86
Kept in incommunicado detention	9	47	Worries about family back home	12	86
Poor access to English language classes	9	47	Worries about lack of medical treatment	12	86
Racist comments	9	47	Forced outside for head counts at night	11	79
Worries about family back home	9	47	Body searches	11	79
Inadequate water in hot weather	8	42	Officials threatening to deport you	11	79
Poor access to school or other education	8	42	Seeing people making suicide attempts	11	79
Officers provoking ethnic conflicts	8	42	Being forced to use unhygienic toilets	10	71
Warned not to speak of experiences to outsiders	8	42	Intentional humiliation by officers	9	64
Separation from family	8	42	Boredom	9	64
Being forced to use unhygienic toilets	7	37	Communication difficulties due to language	9	64
Physical assault by officers	7	37	Officers provoking ethnic conflicts	9	64
Being sworn at	7	37	Poor access to long-term medical care	9	64
Officials threatening to deport you	7	37	Separation of family in different rooms	9	64
Threats of physical violence by officers	7	37	Denied access to basic items	8	57
Separation of family in different rooms	6	32	Not being allowed to receive visitors	8	57
Officers threatening to influence application	6	32	Being told your behaviour affects visa chance	8	57
Being unable to return home	6	32	Poor-quality food	8	57
Intentional humiliation by officers	5	26	Being unable to return home	8	57
Kept in solitary confinement	5	26	Isolation	7	50
Denied access to basic items	5	26	Poor access to school or other education	7	50
Inadequate information about application	5	26	Inadequate information about application	7	50
Being told your behaviour affects visa chance	5	26	Seeing people self-harm	7	50
Breaches of confidentiality by officers	4	21	Separation from family	7	50
Communication difficulties due to language	4	21	No access to English language classes	6	43
Not being allowed to receive visitors	4	21	Poor access to emergency medical care	6	43

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Children ^a	No.	%	Adults	No.	%
Body searches	3	16	Sexual harassment by other detainees	6	43
Delays by officers in response to requests	3	16	Being called a number not a name	5	36
Interviews by immigration officers	3	16	Kept in incommunicado detention	5	36
Being handcuffed during transport	2	11	No privacy when changing (females)	5	36
No privacy when changing (females)	2	11	Sexual harassment by officers	5	36
Not allowed to make or receive phone calls	2	11	No access to adequate legal advice	4	29
Personal documents withheld	2	11	Warned not to speak of experiences to others	3	21
Sexual harassment by officers	2	11	No access to TV, radio etc.	2	14
Sexual harassment by other detainees	2	11	Inadequate water in hot weather	2	14
No access to TV, radio, etc.	1	5	Kept in solitary confinement	2	14
No access to adequate legal advice	1	5	Delays by officers in response to requests	2	14

Note:

(a) Of the 22 children one was too young to be interviewed, one was disabled and could not communicate, and one child was too distressed and refused to be interviewed. Results have been presented for the remaining 19 children.

study, found that 32 of 33 detainees displayed symptoms of major depressive illness with most showing deterioration in their mental state as the length of detention increased. Both studies were undertaken in detention centres in or near major metropolitan centres. The difficulties of undertaking research in these settings was underscored by the fact that the latter study was made possible only because the first author was himself a detained asylum seeker.

There is a dearth of data about the mental health of detained families and children. Large numbers of children have been held in detention during recent years, with 2,184 children detained over the period from July 1999 to 30 June 2003.⁵ Since the height of unauthorised boat arrivals in September 2001, when there were 842 children held in detention, numbers have significantly declined. Nevertheless, at the time of writing (August 2004), 89 children remained in close detention facilities in mainland Australia or in offshore detention facilities.²¹

Sultan and O'Sullivan²⁰ noted high levels of psychological disturbance among children in detention, but they were unable to investigate the extent of the problem systematically. Nevertheless, the investigators had observed cases of separation anxiety, disruptive conduct, nocturnal enuresis, sleep disturbances, nightmares and night terrors, sleepwalking, and impaired cognitive development. Based on clinical impressions, Mares and colleagues²² also raised concerns that detained children may be at risk of emotional disturbances because of confinement, exposure to violence and self-harm, and the impact of parental distress on care-giving. Agencies including the Public Health Association of Australia²³ and the Colleges and Guild organisation²⁴ have raised concerns about the psychosocial well-being of children in detention. Several cases remain under consideration by the Family Court of Australia in relation to the potential psychosocial damage that prolonged detention may incur on asylum-seeker children. In that context, it is imperative to gather systematic data concerning the mental health of asylum-seeker families and children in detention, in spite of the administrative obstacles facing researchers in so doing.

The aim of the present study was to document the psychiatric status of a near-complete sample of children and their families from one ethnic group held for an extended period of time in a remote immigration detention facility in Australia.

Method

Sample

Ten of 11 eligible families from the same ethnic background held in a remote detention centre were interviewed. Families were identified by legal workers preparing a submission challenging the legality of detention of these families. To protect anonymity, in accordance with advice from the University of New South Wales Ethics Committee, the nationality of the detainees and the detention facility will not be disclosed.

There were 14 adults and 22 children with family composition ranging from two to six persons. Six families had one parent, and four families had both parents residing in detention. Children included 13 boys and nine girls with ages ranging from three to 19 years. The age range for adults was 28 to 44 years, with nine being women and five men. Two children could not be assessed because one was too young and the other was unable to communicate due to disability. Another boy was too distressed to speak directly to interviewers but he agreed to have his mother relay his experiences.

Measures

General measures

Demographic/historical information. General demographic, migration and historical data were obtained using methods applied in previous studies among asylum seekers.^{25,26} The approach facilitates engagement of the person, beginning with a free-flowing account of their history and leading towards the completion of a semi-structured inquiry.

Detention experiences checklist. All investigators have had

extensive experience working with asylum seekers. A checklist of common experiences in detention was developed from reports provided by current and past detainees who had been interviewed previously by members of the research team. The checklist was based on the format of the previously designed post-migration living difficulties checklist²⁷ and covered 60 key experiences (see Table 1 for a list of the items). If the experiences were endorsed, respondents rated them on a four-point scale, ranging from 'no problem at all' to 'a very serious problem'.

Detention symptom checklist. A list of nine stress symptoms adapted from standard measures of post-traumatic stress²⁸ was developed to assess the extent to which the detention experience specifically was associated with ongoing distress. The checklist covered symptoms such as nightmares and intrusive memories about detention experiences, avoidance of thoughts about detention, and symptoms of anxiety, anger and hopelessness about detention. Each item was rated on a four-point scale ranging from 'not at all' to 'extremely'.

Child-specific measures

Schedule for Affective Disorders and Schizophrenia for School-Age Children – Present and Lifetime Version (K-SADS-PL).²⁹ The presence of psychiatric disorder among children under 18 years was assessed by administration of the K-SADS-PL, a semi-structured clinician-administered diagnostic instrument. The K-SADS-PL is administered by interviewing both the parent and the child and thereby deriving summary ratings based on all sources of information. The K-SADS-PL has good to excellent inter-rater and test-retest reliability, with evidence of high concurrent validity with other established measures of child psychiatric disorder.²⁹ Screens for major depressive disorder, separation anxiety disorder, enuresis, oppositional defiant disorder, conduct disorder, and post-traumatic stress disorder were administered followed by the full module for those who screened positive. Interviews were conducted with both parents and children. To assess the presence of each psychiatric disorder in children prior to detention, the lifetime symptom questions were modified to cover the period prior to arrival in Australia.

Adult-specific measures

Structured Clinical Interview for DSM-IV Axis I Disorders.

Psychiatric disorder among parents and children over 18 years was assessed by the mood disorder and post-traumatic stress disorder modules of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-IV).³⁰ The SCID-IV is a widely employed clinician-administered psychiatric diagnostic instrument with substantial evidence to support its validity, inter-rater and test retest reliability.³¹⁻³³ As with the K-SADS-PL, the SCID was administered to assess both current disorders and disorders prior to arrival in Australia.

Parenting questionnaire. A series of questions about parenting competency and family intimacy in the period before detention and in the one month period prior to assessment were asked of each parent. The questions were constructed by an expert panel

of child psychiatrists and paediatricians for the purposes of the current study (MD, LN, BB, SM – see Table 5). Each question was rated on a four-point scale. Copies of the questionnaire are available from the authors upon request.

Ethical considerations

Legal advice obtained from two specialists in Australian migration and international law indicated that there was no restriction on communicating with detainees for the purpose of research, clinical intervention or report writing. The study was undertaken independently of the private company managing the detention centre at the time of the study, Australasian Correctional Management and the Department of Immigration and Multicultural and Indigenous Affairs since previous attempts to engage the department on issues of research in detention centres had been met with delays and inconclusive outcomes. In light of widespread concern about the psychological impact of long-term detention, we formed the view, supported by the university ethics committee, that there was sufficient scientific, moral, and humanitarian justification to proceed with the study in the manner described. Detainees were able to make and receive phone calls on public phones and this medium was used since there was no other means available to undertake the interviews. The independence of the research team from the Government was indicated in the explanatory documents offered to potential participants. Ethics approval for this methodology was obtained from the Human Research Ethics Committee of the University of New South Wales. The approval was subject to a commitment to maintaining anonymity of all participants, the centre surveyed and the ethnicity of the target group, the latter made possible by the presence of several groups from the same region being in detention. A senior member of the ethics committee reviewed the present manuscript and approved its content prior to submission.

Procedure

Initial contact was organised by legal workers who were preparing submissions for the families held at this remote detention facility. Because the legal team had made contact with all families from one of the largest ethnic/language groups, it was decided to restrict the survey to that subpopulation. Information sheets and consent forms were forwarded to the identified families. Written, informed consent was thus obtained from all participants, and from a parent/guardian in the case of children. Access to counselling support within the centre was ensured in the event of significant distress being identified or precipitated by the interview. All families were offered medico-legal reports in support of the aforementioned legal submissions arising from the interviews irrespective of whether they agreed to allow the information collected to be used in the study. Ten of the 11 families agreed to participate in the research component. A toll-free number was established for detainees to contact the research team.

Members of the paralegal team made contact with the detained families and organised times for them to phone the research team using the payphones that were available for detainees to use within

the detention compound. Each interview with a family member lasted from one to three hours and in some instances was undertaken over a series of telephone contacts. Assessments were generally carried out during the mornings so as not to interfere with the access of other detainees to the payphones. Some children who attended school were interviewed during the afternoons.

The assessments were undertaken between September 2002 and February 2003 by three same language-speaking psychologists with prior professional experience working with refugees from the relevant ethnic background. Recognising the potential bias of interviewers identifying with the plight of asylum seekers, the three interviewers were encouraged to apply conservative criteria in identifying disorders by consensus according to the SCID-IV and K-SADS-PL. ZS reviewed all diagnostic material and subsequent reports as a secondary check on the validity of the data. Diagnostic information was available for 20 children. Self-report data were complete for 19 children and 14 adults.

Results

Ten of the adults were Muslim and the remainder were Christian or of other religious backgrounds. The average period of detention was two years and four months (range: two years to two years and eight months). All adults reported traumatic experiences in their country of origin, with it being common for one parent to have been imprisoned and tortured for political reasons. All families reported fleeing their country of origin out of fear for the life of one or all of the family members. Eight families had left their country of origin without official permission, and all had travelled via South-East Asia and then by boat to Australia from Indonesia.

A number of the families (five) reported traumatic boat journeys. Some boats broke down (two families) or were attacked by pirates (one family), children in one family became very unwell and were close to dying, others (three families) had to go into hiding in Indonesia for months and some were detained by Indonesian authorities. All families had arrived in Australia without authorised entry documents and had lodged applications for refugee protection with the Department of Immigration. In all instances, applications had been refused. The families had been held in a number of detention centres since their arrival and all had lodged appeals against their negative refugee determinations, with the majority of these appeals already being refused.

All families reported that the education provided for children in detention had been inconsistent. At times, children in detention had attended classes, but often a single class included children of a wide range of ages (two to 18 years). The older children reported feeling humiliated in such settings. At times, children were allowed to attend school outside the centre, but they described being transported in a prison bus and being subject to verbal abuse from other children at the school for being prisoners. Two children over 16 years reported being denied schooling despite their repeated requests, on the grounds that they were "too old". They were 18 and 19 years respectively at the time of the study, and they had not received any education for the previous two years.

Trauma exposure in detention

For evident reasons, the researchers could not obtain independent verification of the experiences asylum seekers reported in detention. All families described traumatic experiences in detention, such as witnessing riots in which guards in riot

Table 2: Current and lifetime (prior to detention) psychiatric disorders and reports of suicidal ideation and self harm among 14 detained parents.

Case no.	Prior to detention				At assessment			
	D	P	SI	SH	D	P	SI	SH
1		+			+	+	+	
2		+			+	+	+	+
3	+	+			+	+	+	
4					+	+	+	
5	+	+			+	+	+	
6		+			+	+	+	+
7					+	+	+	
8	+	+			+	+	+	+
9					+			
10		+			+	+	+	+
11					+		+	
12					+	+	+	
13					+	+	+	
14					+	+	+	+
Total	3 21%	7 50%	0 0%	0 0%	14 100%	12 86%	13 93%	5 36%

Notes:
D = major depressive disorder; P = post-traumatic stress disorder; SI = suicidal ideation; SH = self-harm.

uniform hit detainees with batons; detainees fighting each other; fire breakouts; detainees publicly committing acts of self-harm; and witnessing suicide attempts. Table 1 ranks experiences by severity of distress for the 60 detention items. Children (16, 84%) and adults (13, 93%) reported extreme distress associated with fear of being sent home. Being called by a number and not by a name was rated as a serious problem for children (nine, 47%), but less so for adults (five, 36%). Physical assault by detention officers was alleged by children (7, 37%) and most adults (12, 86%). A number of families reported enforced periods of separation from each other during detention (seven families), often when a parent was taken to solitary confinement either as punishment or in response to self-harm attempts. Few adults (one, 7%) or children (two, 10%) rated access to media such as TV and radio, or to legal advice, as a serious problem.

Some items were reported more frequently by children. There were a number of incidents where children, including those under 10 years of age, were separated from their primary care giver(s) for extended periods of time. Children commonly reported distress associated with witnessing acts of self-harm and suicide by other detainees. All of the children witnessed the same act of self-harm by an adult detainee who repeatedly mutilated himself with a razor-blade in the main compound of the detention centre. Children

also described having witnessed detainees who had slashed their wrists, jumped from buildings and attempting to strangle or hang themselves with electric cords. At times, children witnessed suicide attempts by their parents, or their parents being struck by batons. A number also witnessed their friends and family members harming themselves (eight children). All children reported boredom, isolation and poor-quality food in detention. They also identified poor access to medical and dental services and counselling.

Adults gave greater emphasis to problems related to the refugee determination process and to issues arising from treatment by detention officers. Problems cited included delays in processing applications, interviews by immigration officials, claims of breaches of confidentiality by detention centre officers, being handcuffed during transport, and alleged racist comments by officers. All adults indicated that restrictions on phone calls constituted a serious problem.

Psychiatric disorders

The results of the psychiatric assessments are displayed in Tables 2 and 3. The prevalence of psychiatric disorders appeared to increase markedly from the period prior to detention (as reported retrospectively), to the point of assessment in detention. Half of

Table 3: Current and lifetime (prior to detention) psychiatric disorders and reports of suicidal ideation and self harm among 20 detained children.

	Age	Prior to detention						At assessment							
		D	P	SA	OD	EN	SI	SH	D	P	SA	OD	EN	SI	SH
1	6-10								+	+	+	+	+		
2	6-10								+		+				
3	6-10								+		+				+
4	6-10								+	+	+	+	+		
5	6-10								+	+	+		+	+	+
6	6-10			+					+		+	+	+		+
7	6-10								+		+		+		+
8	11-15								+	+	+	+		+	+
9	11-15	+	+	+					+	+	+	+		+	
10	11-15								+	+	+			+	
11	11-15								+	+				+	
12	11-15											+			+
13	15+								+			+			
14	15+	+							+						+
15	15+								+			+		+	
16	15+								+						
17	15+								+	+				+	
18	15+								+	+					
19	15+								+	+				+	
20	15+								+	+				+	
Total		2	1	2	0	0	0	0	19	10	10	9	4	11	5*
		10%	5%	10%	0%	0%	0%	0%	95%	50%	50%	45%	20%	55%	25%

Notes:

D = major depressive disorder; P = post-traumatic stress disorder; SA = separation anxiety disorder; OD = oppositional defiant disorder; EN = enuresis; SI = suicidal ideation; SH = self-harm.

the adults suffered from post-traumatic stress disorder (PTSD) prior to detention as a result of traumatic experiences in their country of origin and a small number had co-morbid depression (three, 21%). At assessment, every adult was diagnosed with a major depressive disorder and the majority (12, 86%) also were diagnosed with PTSD. Two (14%) adults had evidence of psychotic symptoms and met criteria for a severe major depressive disorder with psychotic features, and both had made previous suicide attempts.

The reported increase in suicidal ideation was substantial: none of the adults had experienced persistent suicidal ideation prior to detention. At the time of assessment, almost all adults (13, 93%) experienced persistent thoughts of killing themselves, describing potential methods such as taking pills, cutting wrists or drinking detergent. A third of adults had harmed themselves (five, 36%), two people had struck their heads violently and repeatedly against walls, two had slashed wrists (one of these also consuming poison and embarking on hunger strike), and one had made two suicide attempts with an overdose of paracetamol and drinking disinfectant. The remainder who expressed suicidal ideation without taking action reported that the only constraint was concern for their children.

Retrospective reports indicated low levels of psychiatric disorders in children prior to arrival in Australia. One child who had witnessed severe domestic violence had multiple previous disorders. In contrast, at the time of assessment, after having spent in excess of two years in detention, all children were diagnosed with at least one psychiatric disorder and most (16, 80%) were diagnosed with multiple disorders, representing a tenfold increase in the total number of diagnoses identified. Two children were diagnosed with all five of the psychiatric disorders assessed. All but one child received a diagnosis of major depressive disorder and half were diagnosed with PTSD. In some cases, symptoms of PTSD seemed directly related to experiences in detention, with children describing nightmares about being hit by officers. Parents commonly reported that children (13, 65%) woke up screaming or shouting when asleep. Half of the children manifested separation anxiety disorder, while the majority of other children

experienced persistent symptoms of separation anxiety not reaching diagnostic threshold.

Enuresis is a disorder of middle childhood and over half of the children of that age group suffered from the disorder, regularly wetting themselves three or more times a week. In all but one child, there was no history of bed-wetting prior to detention. Almost half the children met criteria for oppositional defiant disorder. More than half of the children regularly expressed suicidal ideation, and many thought it would be better if they were dead. A quarter (five) had harmed themselves either by slashing their wrists (three) or striking their heads against walls (two).

Detention-related traumatic symptoms

The results of the detention symptoms checklist are presented in Table 4. All adults and the majority of children reported that they were bothered a lot or extremely by sudden and upsetting memories about detention, intrusive images of events that had occurred in detention, feelings of sadness and hopelessness about detention and episodes of anger in the week prior to interview. All other detention symptoms assessed were endorsed by all but two adults and by the majority of children.

Effect of detention on parenting

Table 5 presents comparisons of adults' accounts of their pre-detention and detention parenting capacities. All parents reported that they were able to care for, support and control the behaviour of their children adequately prior to detention, but only one parent reported such abilities since being in detention. Most parents reported having their parenting abilities undermined by detention.

Discussion

In combination with the research by Mares and Jureidini,³⁴ this study is the first of its kind nationally and internationally to report the mental status of whole families held in asylum detention centres. All families had been held in detention for two or more years. All adults and children met diagnostic criteria for at least one current psychiatric disorder. Based on retrospective

Table 4: Adults and children (n, %) reporting being bothered a lot or extremely by symptoms associated with negative detention experiences in the week prior to interview.

	Adults (n=14)		Children (n=19)	
	n	%	n	%
I have sudden and upsetting memories of the time in detention	14	100	17	90
I have images of threatening or humiliating events in detention	14	100	17	90
Since I have been in detention, I have sudden attacks of anger over small things	14	100	17	90
When I think about detention, I feel extremely sad and hopeless	14	100	17	90
I avoid talking about detention because it upsets me	13	93	17	90
Since being in detention, I avoid interacting with other people	13	93	16	84
If I think about detention, I become nervy, sweaty, shaky and/or have rapid heart beat	13	93	15	79
I have nightmares about the things that have happened to me in detention	12	86	14	74
My feelings are numb since I was in detention	12	86	10	53

comparisons, adults displayed a threefold and children a tenfold increase in psychiatric disorder subsequent to detention. The majority of adults (86%) and children (80%) had more than one psychiatric disorder. In total, there were 26 current psychiatric disorders identified among 14 adults, and 52 psychiatric disorders among 20 children, rates that are many times higher than found in the host Australian population of adults³⁵ and children.³⁶ It is noteworthy that the prevalence rates were also substantially higher than those found in general refugee populations, including children, who have not been in detention.³⁷⁻³⁹ Persistent suicidal ideation was reported by all but one adult and by over half of the children. Five adults and five children had engaged in acts of self-harm or attempted suicide.

The accounts provided by the families indicated that exposure to trauma within the detention camps was commonplace. All adults and the majority of children were regularly distressed by sudden and upsetting memories about detention, intrusive images of events that had occurred in detention, and feelings of sadness and hopelessness about being in detention. The majority of parents (13 of 14) felt they were no longer able to care for, support, or control the behaviour of their children, whereas all parents had felt able to do so prior to being detained.

The strengths and limitations of the study need to be acknowledged. Unlike any other investigation into asylum detention, the study was able to recruit a near-complete population of detained families (10 of 11 families) from one language group in a single remote detention facility. While limiting generalisability to other populations in detention, the design minimises the possibility that only the more severe cases from a particular group were identified for assessment. Psychiatric disorder was determined using validated psychiatric diagnostic instruments with ratings made by three same language-speaking psychologists, all with previous experience in assessing refugee populations from this language background. Diagnosis was based on consensus agreement between the clinicians, thereby aiming to reduce bias. The measures are designed so as not to depend on direct mental state observations, making it feasible to apply the instruments by telephone. Previous studies comparing face-to-face and telephone

interviews using structured interviews have yielded high levels of diagnostic agreement.^{40,41}

Psychiatric disorder prior to detention in Australia was based on retrospective reports, an approach that could have introduced inaccuracies in recall. To minimise the impact of this bias, the diagnostic instruments were selected because they had been validated for use in the assessment of lifetime prevalence estimates, with only the timeframe modified in the present study to reflect the period prior to detention. In partial support of the validity of the retrospective assessments was the finding that the prevalence of pre-migration psychiatric disorder reported by the adults was similar to rates identified in other post-conflict populations.⁴²⁻⁴⁴ The possibility of transcultural error should also be noted, although as indicated the diagnostic instruments were administered by bilingual psychologists from the same language and cultural group. A number of the measures employed to assess detention symptoms and parenting competency were developed specifically for this study and have not been independently validated. To this end, no attempt was made to report findings as validated scales with only individual item frequencies presented in the results.

The possibility that respondents may have exaggerated their reports of experiences and symptoms in detention must be acknowledged. Yet, a number of observations suggest that accounts may have been accurate. Each family unit was interviewed separately but there was notable consistency across families in reports of publicly witnessed incidents that had occurred in detention. Several families were held in different compounds within the detention facility, reducing the likelihood of contamination by discussion among respondents in intervals between interviews. Similarly, interviews with parents and children were generally carried out at separate times, yet reports of symptoms experienced by children, particularly when they concerned overt behavioural disturbances, showed a high level of consistency. Similarly, siblings corroborated accounts given by other children and parents. The behavioural disturbances and disorders identified are consistent with other less systematic reports about the problems faced by children in these settings^{20,22} and in particular are consistent with the findings reported by Mares

Table 5: Parental self rating of parenting ability and family cohesion prior to being in detention and in the month preceding interview.

	Before being in detention		In the month prior to assessment	
	n	%	n	%
Able to care for and support children (mostly/very much)	14	100	1	7
Able to control the behaviour of children (mostly/very much)	14	100	1	7
Feel like good parents (mostly/very much)	14	100	4	26
Members of family have clear positions and roles (mostly/very much)	13	93	4	26
Members of family show affection for each other (a lot/extremely)	14	93	6	43
Members of family able to talk about their feelings to other family members (mostly/very much)	13	100	5	36
Members of family involved in each other's lives (a lot/extremely)	11	79	6	43
Family's ability to cope with problems (good/excellent)	13	93	4	26

and Jureidini,³⁴ which were based on longitudinal clinical assessment across the course of treatment.

In addition, responses to the detention experiences checklist evinced a wide range of responses with many items being regarded a problem in only the minority, not a pattern that would be expected if an exaggeration bias was operating across the sample as a whole. Hence, although the potential for bias cannot be entirely dispelled, the coherence of the data and their convergence with clinical observations^{20,22} and reports of extensive inquiries undertaken in detention centres^{1,4,6,34,45} builds a case to support the validity of our findings.

The results, taken in concert with the existing evidential base, raises further concerns about the mental harm that is associated with the continued use of mandatory detention as a policy in Australia. The key public health dilemma to emerge from this and other such research is that the Australian Federal Government has, and continues to be, unresponsive to findings regarding detention practices, choosing instead to attempt to challenge the validity of the research and the integrity of the researchers involved (see Ruddock^{46,47}). It would appear that any reasonable and dispassionate assessment of the evidence base leads to the ineluctable conclusion that Australia's detention policies are associated with adverse mental health effects that are contrary to the principles of public health. As argued by a number of commentators,^{10,14,48} the moral and ethical imperative of health professionals and their representative organisations in such circumstances is to continue to document and publicise the manifest harm being perpetrated, to advocate and support asylum seekers subjected to these inhumane policies, and to strive through all ethical means for political change.

Conclusions

The rates of psychiatric disorder documented among the 10 families surveyed in the present study are at a level that should raise concern among health professionals, even given the limited sample size. The data obtained should be considered carefully in future policy formulation on the treatment of asylum seekers and may be used by health professionals to advocate for the implementation of more humane immigration policies. Alternatives to prolonged detention are available, particularly systems involving bonds, the use of open hostels, and/or the close monitoring of asylum seekers in the community. Flight from oppression, the chief reason for seeking asylum, is associated with distress and psychosocial upheaval. It is essential that in attempting to manage the international asylum crisis, countries with a strong tradition of humanitarian refugee policies do not implement approaches that cause further harm to this vulnerable population.

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