

Psychiatric assessment of children and families in immigration detention

– clinical, administrative and ethical issues

Abstract

Objective: This paper reports the clinical, practical and ethical issues arising in the assessment of 10 consecutive referrals from a remote Immigration Reception and Processing Centre to a child and adolescent mental health service (CAMHS) between February and August 2002.

Method: The 16 adults and 20 children (age range 11 months to 17 years) were comprehensively assessed by allied health clinicians and child psychiatrists. All children were also assessed by the statutory child protection agency.

Results: There were very high levels of mood disturbance and post-traumatic symptoms in this population. All children had at least one parent with psychiatric illness. Of the 10 children aged 6-17 years, all (100%) fulfilled criteria for both post-traumatic stress disorder (PTSD) and major depression with suicidal ideation. Eight children (80%), including three pre-adolescents, had made significant attempts at self harm. Seven (70%) had symptoms of an anxiety disorder and half reported persistent severe somatic symptoms. The majority (80%) of preschool-age children were identified with developmental delay or emotional disturbance. Few clinically based recommendations were implemented.

Conclusions: Very high levels of psychopathology were found in child and adult asylum seekers. Much was attributable to traumatic experiences in detention and, for children, the impact of indefinite detention on their caregivers.

Implications: Multiple obstacles to adequate service provision are identified. Adequate clinical intervention and care was not possible. The impact on involved clinicians is discussed.

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In 1990, Australia ratified the United Nation's Convention on the Rights of the Child and this was scheduled into the Commonwealth Human Rights and Equal Opportunity Act in 1993. The United Nations Commissioner for Refugees (UNHCR) Revised Guidelines relating to the detention of Asylum Seekers¹ concluded that detention was undesirable, should not be prolonged and that children should *not* be detained (UN emphasis). The guidelines stress the importance of ensuring a normal home environment for children and access to school and other appropriate support systems.

Since 1992 Australia has had a policy of mandatory detention of all unauthorised arrivals, including families and children seeking asylum. Detention, often in remote or offshore centres, is indefinite while applications for refugee status are processed, or until applicants are removed from the country. This can take years. Australia's policy of detaining accompanied and at times unaccompanied children has attracted considerable domestic and international concern and criticism.^{2,3}

The Department of Immigration, Multi-cultural and Indigenous Affairs (DIMIA) contracts the running of Immigration Detention (IDC) and Immigration and Reprocessing

Centres (IRPC) to a private company, and this contract includes provision of medical care. At the time of these assessments the centres were run by Australian Correctional Management (ACM), which is a subsidiary of an American company, Wackenhut Corporation. Medical and allied health staff employed to work in the ACM Medical Centres were usually subject to contracts that prohibited speaking publicly. When detainees required specialist care or hospital treatment this was provided by privately employed medical practitioners or State Government health services who were reimbursed by DIMIA for treatment of detainees.

This paper describes the findings and experience of a child and adolescent mental health service (CAMHS) that was requested to provide specialist service to detained children and families in a remote IRPC. Referrals to the CAMHS service began after child psychiatrists undertaking assessments to support legal processes expressed significant concern about the mental health of children in this remote location. At the time of the initial assessments there were no confirmed arrangements between State Departments of Health and Community Services for provision of mental health assessment and treatment, or for responding to child protection concerns.

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Psychiatric morbidity among detained asylum seekers

In Australia, access by medical and psychiatric services to detainees in immigration detention is limited and little comprehensive information exists about the mental health of detained asylum seekers, particularly children. Those reports available indicate extremely high levels of psychiatric morbidity in populations of detained adults⁴⁻⁷ in Australia and overseas.

The cumulative developmental impact on children exposed to multiple risk factors, including the mental state and well-being of their caregivers, is well documented.⁸ Children in detention have prolonged exposure to multiple developmental risk factors including direct experience of personal and interpersonal violence, parental mental illness, inadequate parental protection and comfort in a context described as developmentally impoverished.³ The impact of detention on parenting and parenting capacity has been explored in one Australian paper.⁹ Children rely on their caregivers to help them make sense of the world and regulate their own responses to it. Parental mental illness increases children's vulnerability to emotional and behavioural disorders,¹⁰ and post-traumatic symptoms in children are strongly linked to their parents' well-being and level of traumatisation.^{11,12} For young children, witnessing a threat to their caregiver has been identified as the most potent predictor of PTSD.¹³ In the setting of the detention centre parents have at times been the source of their child's trauma as a result of their self-destructive or otherwise disturbed behaviour.

Steel et al.¹⁴ recently surveyed a near-complete sample of children and their caregivers in one remote detention facility. Structured diagnostic assessments were undertaken by telephone with 10 families (20 children and 14 adults). Every adult fulfilled the criteria for major depression and most had PTSD. The majority of children (having spent between 24 and 32 months in detention) fulfilled the criteria for major depressive disorder (19/20); half also had PTSD and some qualified for up to five disorders. Assessment of the lifetime prevalence of psychiatric disorders prior to arrival in Australia showed that experiences in immigration detention contributed significantly to the current high levels of psychopathology. There was a threefold increase among adults and a 10-fold increase among children in the number of psychiatric disorders subsequent to detention. Steel et al. conclude: "The rates of mental illness documented amongst the 10 families surveyed in the present study appear to be unparalleled in contemporary medical literature." One limitation associated with the cross-sectional design of this study is that while the authors employed validated diagnostic instruments, it is possible that some respondents may have exaggerated their reports of experiences and symptoms in detention. This led the then Minister for Immigration, Mr Phillip Ruddock, to reject the findings, stating that the study by Steel et al. was based on "telephone interviews without a full knowledge of any pre-existing health conditions, or any interventions undertaken by the department and the specialists involved in treating the children".¹⁵ The present study addresses the potential limitations of this previous research by

reporting the findings from a consecutive series of families referred to the CAMHS. Information obtained in a series of detailed clinical interviews, undertaken by a range of experienced mental health clinicians over time, was used to develop consensus diagnoses on each individual child and adult assessed. This methodology is consistent with Spitzer's descriptions of the LEAD approach,¹⁶ widely regarded as the contemporary gold standard of psychiatric diagnosis.

The setting

The IRPC was situated in a remote location outside a small township several hundred kilometres from the State capital.

Method

This paper reports the assessment process and clinical outcomes for 10 consecutive referrals from this remote detention centre to a CAMHS between February and August 2002 (see Table 1). These 10 families from Iran, Iraq, Afghanistan and Palestine included 16 adults and 20 children aged from 11 months to 17 years, and represented approximately half of the children and families in the IRPC at that time. One of the children had been born in detention, and another has been born subsequently. There were two sole parent families and one unaccompanied minor in the group assessed. All families had arrived by boat in northern Australia after fleeing their country of origin and boarding boats in Indonesia, sometimes after a protracted wait for refugee determination through the UNHCR. At the time of assessment all the families had been in detention between 16 and 20 months and had experienced at least one refusal of a visa application.

Referrals were initiated by a primary care physician contracted by ACM to provide services to the IRPC and a psychologist employed by ACM who was in the IRPC on a six-week contract. Once this psychologist left, referrals ceased, and some referrals made by her, but not yet acted on by CAMHS, were withdrawn. The stated reasons for referral varied with the age and situation of the children and families. Most involved requests for assessment

Table 1: Population sample.

Remote centre study – population sample	
	Referred clinical population
10 families	3 language groups 3 religious groups
16 adults	Age range 19-60 years (av. 35.5 years) 7 men 9 women
20 children	14 boys, 6 girls, aged 11 months to 17 years
Family structure	7 two parent, two sole parent, unaccompanied minor
Average time in detention at initial contact	1 year 3 months at initial contact (range 12 to 18 months)
Method	Comprehensive clinical assessment, multiple interviews
Conducted	February to August 2002 Followed to September 2003

as a result of threatened or actual self harm by the child, concerns about the children's well-being because of parental mental illness or self harm and/or notification of the child(ren) to child protection services in response to alleged parental neglect or abuse in the context of parental mental illness. The CAMHS staff were not privy to decision making by the referring practitioners about what constituted grounds for referral. Following referral, the CAMHS immediately allocated a team member to assess each family referred from the IRPC. Clinicians encountered substantial difficulties obtaining access to referred families with assessments repeatedly cancelled by the detention provider on the grounds that they could not provide transport or they had concerns about centre security.

All initial assessments required interpreters and took place either within the medical centre at the IRPC or at local hospital or city-based services. Assessment took on average 20 hours per family and followed the service's clinical guidelines for the assessment of children and families. All but one family (assessed by another senior child psychiatrist) were seen at least once by one of the authors. Four of the parents also had emergency assessments by psychiatrists working with adult services and required psychiatric admission to the local hospital or city-based adult psychiatric services. All preschool-age children received an initial developmental assessment by a child development team from a tertiary children's hospital.

Each family was discussed at regular telephone link-ups involving senior mental health and child protection clinicians. Management plans were developed at these meetings. Follow-up was provided in all cases, usually fortnightly or monthly. Assessment was usually protracted with frequent delays and cancellations as detailed above. All assessment included questions intended to determine the source of troubling or intrusive memories associated with PTSD symptoms. This included questions about traumatic experiences prior to arrival in Australia. Clinical recommendations were not implemented, new crises arose and children and their parents deteriorated as time passed.

All children were also assessed by the state child protection agency, often many times, on the grounds that they were subject to significant abuse or neglect. In every case, that agency confirmed that abuse had occurred. During the period reported none of the children were removed from the centre in response to these child protection notifications and assessments.

Results

Adults

All children had at least one parent affected by psychiatric illness. Only two parents gave a history of depression or other psychiatric illness prior to arrival in Australia, but only two of the 16 adults did not meet criteria for a psychiatric illness at the time of our assessment, and in five of the seven dual-parent families both parents had psychiatric illness (see Table 2). In both sole-parent families, the mother had required several hospitalisations for psychiatric treatment. Fourteen of the 16 adults (87%) fulfilled criteria for major depression, nine of 16 (56%) met criteria for PTSD and four had

psychotic illness requiring hospitalisation. Five (31%) had made significant, often multiple attempts at deliberate self harm.

Children under five years old

Of the 10 children five years and under, seven had spent at least half their lives in immigration detention. Five (50%) presented with delays in language and social development and/or emotional and behavioural dysregulation. Their parents reported that the children had disturbed sleep and feeding routines and complained that they "didn't know how to play", and no longer obeyed them. Three of the infants (30%) showed marked disturbance in their behaviour and interaction with their parent or carer, indicating disturbances or distortion of attachment relationships. All of these children had been exposed to violence and chronic parental mental illness. Over the 12-month follow-up, oppositional behaviour and parent-child relationship difficulties were identified in a further three children, indicating that 8/10 preschool children had displayed some form of developmental or emotional disturbance.

Example 1:

In the richer environment in which assessment occurred, 'A' aged 3 moved busily from one activity to another, eagerly seeking to use toys in a way that suggested he had never before seen a puzzle, or scissors, and that he was uncertain what to do with a picture book. His mother initially smiled and then wept as she watched his pleasure at exploring the toys and the room.

Example 2:

'M' aged 3 sat in the corner eating bits of foam rubber and paper rather than exploring the toys. He repeatedly ran out of the room despite being told not to. His behaviour was restless and disruptive. When seen with other children he was aggressive without provocation, hitting, biting, spitting and swearing in English although all his other words were Arabic.

Example 3:

When seen with her mother, 'L', an 18 month old, was unhappy and unsettled and made little eye contact with mother or the interviewer. She demonstrated persistent fussing and whining, and when offered food, drink or toys, threw these away. She was unable to settle enough to explore toys. Although appearing to seek comfort from her mother, she struggled when picked up. This child had been notified to child protection services after her parents had placed sticky tape over her mouth in an attempt to keep her quiet after conflict with other detainees in the shared accommodation who were complaining about the toddler's constant crying.

Children aged 6-17 years

Of the 10 children aged 6-17 years old, all (100%) fulfilled criteria for post-traumatic stress disorder (PTSD). All were troubled by

Table 2: Results, adult psychopathology.

Diagnosis	Sample 16 adults age range 19-60 years	
Major depression	14/16	87%
PTSD	9/16	56%
Psychosis	4/16	25%
Other factors		
Self harm	5/16	31%
Psychiatric admission	4/16	25%

experiences since detention in Australia. Only one also reported troubling thoughts about events on the boat to Australia, although all were asked about this. All had witnessed attempted hangings, slashings and self-poisoning and each reported graphic intrusive memories and thoughts of adults self-harming. For some this included memories and images of their parents during and after self harm. One child had witnessed her mother cut herself and write on the wall in her blood. Another had seen his parent attempting to set fire to herself during a psychotic episode. All 10 reported anxiety about their parents' well-being.

Example 4:

'N', 'aged 12, drank coffee in an attempt to remain awake all night for fear that his depressed mother or psychotic father (whom he had witnessed dancing naked in the camp) might come to grief without his vigilance. He had been victimised by other detainees and guards because of his father's bizarre and provocative behaviour.

Within the IRPC there were times when self-destructive behaviour had escalated to daily cuttings, hanging attempts and provocation of conflict with ACM staff by children, adolescents and adults. Several children expressed a fear of harming themselves "because everyone does it here".

All reported trouble sleeping, poor concentration, little motivation for reading or study, a sense of futility and hopelessness and overwhelming boredom. All children were troubled by recurrent thoughts of death and dying. All children in this age group (100%) fulfilled the criteria for major depression with suicidal ideation (see Table 3). Some were angry, but for others this had given way to despair. Withdrawal and emotional numbing were prevalent. One 13-year-old said, "my heart has become hard". Nightmares were very common, and three (30%) of the younger children reported frequent nocturnal enuresis since being in the IRPC.

All reported recurrent thoughts of self harm. Three pre-adolescent children (aged 7, 10 and 11 years) were among the eight (80%) children who had acted on these impulses, some self-cutting, but others making potentially lethal attempts, by hanging. This is different from patterns seen in community samples where deliberate self harm is rare in pre-adolescent children.^{17,18}

Seven (70%) also had symptoms of an anxiety disorder (panic disorder, generalised anxiety disorder, separation anxiety). Half (50%) reported persistent severe somatic symptoms, particularly headaches and abdominal pain.

All children reported extreme boredom, anxiety about falling behind in their schoolwork and shame about knowing less than age-appropriate peers. A common preoccupation among the children was the apparent randomness of the refugee determination process. Children could not understand why other families that they had met in the IRPC had now been granted visas and they had not. The sense of injustice arising from this was in turn associated with extreme feelings of anger and self worthlessness. One girl said: "What kind of bad person am I that this has happened to me?"

Parents frequently reported that they had in part left their country of origin out of fears that their children were at risk of violence or persecution for religious or political reasons or had limited access to education and other resources. All expressed considerable guilt and despair about bringing their children into a traumatising and hopeless situation. Some expressed a wish to die in the belief their children might fare better without them.

Example 5:

'S' (mother) said 'Leave me in the camp to die, but please get my children out of there'.

'P' attempted to have her son adopted by another family, believing he was better off without her.

'Z' was reported by her daughter to have said, 'you don't have a mother any more. Go on with your life and be a good girl.'

Many of the children had assumed adult roles and responsibilities, surrendered by their parents because of their own ill-health.

Example 6:

'T', an 11-year-old girl, was doing most of the parenting for her five siblings under six. Both parents were depressed and overwhelmed.

'R', an 11-year-old boy, was left to care for his younger brother during many weeks that their mother was in hospital with psychotic depression.

There is incomplete information about the extent of prescribing

Table 3: Diagnosis – 10 children aged 6-17 years.

ID	Age at referral	Male/female	Major depression	PTSD	Anxiety disorder	Enuresis	Somatic symptoms	Deliberate self harm
1	17	F	*	*	*		*	
2	17	M	*	*				*
3	14	M	*	*				*
4	13	F	*	*	*		*	*
5	13	M	*	*	*	*	*	*
6	12	M	*	*			*	*
7	12	F	*	*	*			
8	11	F	*	*	*	*	*	*
9	10	F	*	*	*			*
10	7	M	*	*	*	*		*
Totals	10		10	10	7	3	5	8
			100%	100%	70%	30%	50%	80%

of psychotropic medication to these families during this period. Information about medical treatment provided by ACM medical staff, the primary care physician or adult psychiatric or other visiting services was frequently not available to CAMHS staff despite verbal and written requests. The lack of comprehensive information about prescribing of psychotropics and compliance by detainees with such prescription has clear health and welfare implications for the population and service implications for staff.

Recommendations and their implementation

In each case, comprehensive mental health assessment of children and parents resulted in recommendations that adequate treatment was not possible while they remained in the IRPC environment. In no case was it judged that medication or other intervention carried out while the family remained in detention could be expected to have a significant impact on morbidity (although in the majority of cases some intervention, e.g. for nightly visits for therapy, was also recommended in the hope of lessening suffering). In no case was the primary recommendation by the CAMHS team implemented by the detention authorities.

Family circumstances 12 months after initial referral

In September 2003, 12 months after initial referral, five of the 10 families remained in detention, now for periods up to 30 months (see Table 4). Another child had been born, and further admission of adults for individual psychiatric treatment had occurred.

Of the five families still detained in September 2003, three remained in an IRPC and two had been relocated to a remote community housing project where the father was required to remain in the IRPC with infrequent access to the family. The well-being of all five families deteriorated during the course of the year's follow up, with members becoming increasingly agitated and suicidal as time in detention passed. Further riots and fires had occurred and although schooling opportunities for the children had improved, all children continued to have a limited range of developmentally appropriate experiences and were exposed to continuing trauma and parental illness and distress.

Two families, and an unaccompanied minor, were released on temporary protection visas (TPV) from detention centres during the six months after initial assessment and two in the month prior to writing. None of the releases were in direct response to CAMHS recommendations and in one family the mother and children were granted temporary protection visas but the father was not. The

average length of time in detention for those five families who received visas was 24.8 months (range 12 to 30 months). Most family members reported an initial improved sense of well-being on release from the IRPC, either on TPV or into community housing, despite in one case separation from the father, but such improvements were short-lived in all but two cases. The lack of sustained improvement in those released on TPVs might be due to the fact that their long-term future remained unclear. There is evidence in adult populations that TPV holders in the community have higher levels of distress than those granted permanent residency, and that they may in fact suffer "anticipatory PTSD".¹⁹

Discussion

Comprehensive assessment of these children and their parents by experienced clinicians over time identified distressingly high levels of psychopathology similar to those identified by Steel et al.¹⁴ in their survey. The strengths of this report lie in the direct clinical assessments and the involvement of at least two experienced clinicians with each family in order to reach a consensus diagnosis over time. The diagnostic procedure employed in this study addresses the perceived limitations of previous cross-sectional assessments, which have been alleged¹⁵ to be unreliable, as respondents may have exaggerated their reports of experiences and symptoms in detention. A possible weakness of this study is the lack of standardised structured diagnostic assessment tools, which have been demonstrated to be more accurate in identifying multiple disorders. For example, Steel et al.¹⁴ reported high rates of oppositional defiant disorder and separation anxiety disorder among older children. Because the major and immediate focus of concern in the current study was assessment of safety, in the context of threats of self-harm or severe parental mental illness, rather than establishing diagnosis, under-diagnosis was possible.

Another limitation of our study was the relatively small number of families assessed. There did not seem to be any system as to which families were referred; however, even if only the most disturbed families were referred for assessment, those referred constituted half of the total population of detained families in this facility, so that rates of psychiatric illness would still be remarkably high.

Compromised clinical standards

Mental health services available to families in immigration detention are significantly compromised, not only because of limited access to clinicians but because recommendations aimed at improving detainees' psychological and social circumstances cannot be implemented. In child and family psychiatry, assessment is centred around consideration of the impact of systemic and family factors on well-being and development, rather than simply a focus on individual diagnosis. Similarly, intervention in child psychiatry is likely to address family and broader systemic issues, aimed at facilitating normal development and preventing psychopathology. Adult psychiatric services generally focus on the diagnosis of a psychiatric illness in an individual, to whom intervention is then offered. In practice, particularly in acute

Table 4: Family circumstances 12 months after referral, September 2003.

Sample	10 families
Remaining in IRPC	3 (7 adults, 6 children)
Community detention	2 (2 adults, 3 children)
TPV/humanitarian visa	5 (7 adults, 12 children)
Average time in detention prior to granting of visa	24.8 months (range 12 to 30)

situations, the biological aspects of intervention may take priority (although they would rarely be the sole intervention). It has been argued that in the absence of a clear diagnosis, or diagnosis of an adjustment disorder related to the detention context, the psychiatrist has little to offer the detainee in the IRPC. Particularly in the case of families in immigration detention a narrow, 'biological' approach significantly devalues the environmental and systemic context of psychopathology that is overwhelming in the detention context. Unfortunately, perhaps because of an inadequate understanding of this systemic context, we observed cases in which adult services underestimated or ignored the impact of parental mental illness or hospitalisation on the detainees' children, and children were left effectively unattended or in ad hoc care in the IRPC.

It was not the role or intention of the CAMHS staff to use assessment as a platform for political debate. However, once CAMHS staff had become involved in these cases it was not possible to set aside the significant and ongoing developmental impact of the impoverished and traumatising detention environment and continuing parental mental illness. Therefore, recommendations about the mental health of children, all of which were based on clinical assessment, necessarily included statements about the needs of their parents and the need for removal of families from detention. These assessments and reports were not acted upon, despite the extent of the psychopathology identified. This experience called into question the clinician's role in attempting to provide a service in this environment. The difficult moral and ethical issues posed to psychiatry as a profession by this aspect of federal policy has been discussed by Silove.²⁰

The question of whether it is possible to be therapeutic in this context remains moot. For some families, ongoing support included a trip out of the IRPC and for separated families, a chance to see their father or husband. Families reported the benefits of these visits as primarily breaking the monotony of camp life, but resulting in no substantial change. Clinical staff found themselves bearing witness to families whose mental health and overall functioning deteriorated as their time in detention extended. This pervasive deterioration also raises serious concern and is at odds with international research demonstrating improvement over time among refugees and post-conflict populations.^{21,22}

State/Commonwealth issues

State and Commonwealth tensions are brought into focus by health and child protection concerns about these children, all of whom were known to State child protection services. Given that the Federal Minister "as a matter of policy is not prepared to release the whole family into the community" (p 22.14), Layton²³ notes the "State has no jurisdiction to require the release of a child's family from the detention centres in order to ensure the best interests of the child" (p 22.12). This release can only be achieved with the co-operation of the Federal Minister. Thus as Justice Bhagwati, chairman of the United Nations Human Rights Committee, notes:³ "the Minister for Immigration is both the 'detainer' and the guardian, which represents a serious conflict of interest" (quoted in Layton, p 22.10).

Layton notes "the [Memorandum of Understanding between State and Federal Governments] does not recognise the serious systemic abuse of children in detention and that the most serious abuse does not come from individuals, but arises from the circumstances of detention itself" (p 22.14). At the time of writing a number of legal attempts to test and explore jurisdictional areas of responsibility and power in relation to care and protection of these children are under way.

Impact on involved clinicians

The CAMHS and staff undertook this work with the same commitment to early intervention and prevention, an emphasis on optimising developmental potential, and understanding children's difficulties in the context of their family and social environment as is demonstrated in response to all appropriate referrals to the service. Staff involved in these attempts at service provision were responsible for, but felt unable to assist, children and parents with severe psychiatric illness and distress. Extensive time was spent in negotiating the numerous administrative and practical obstacles encountered in responding to referrals. There was potential for significant vicarious traumatisation of workers. Out of sight has not been out of mind, and involved clinicians report carrying with them feelings of impotence, anger, hopelessness, avoidance, numbing, sadness and despair, feelings resonating with those experienced by detainees.

Over and above their statelessness and their cultural and religious isolation, adults and children in immigration detention are alienated by their official status as 'unauthorised non-citizens'. The clinician encounters a system within which not only those they advocate for, but they themselves have little power. Because Australian immigration law takes precedence over State health and child protection jurisdictions, the clinician is unable to effect significant change. Some clinicians felt that their expertise had been denigrated; others felt impotence and guilt that so little was achieved to protect patients from the effects of ongoing incarceration that occurs in our name, apparently with majority public support.

To maintain staff moral and to share the clinical and emotional burden of the work, a number of strategies were put in place. These included allocating assessment and follow-up of families across a number of country area teams and limiting the number of families from the IRPC carried by any one clinician. Visits to the IRPC to conduct assessment and follow-up were undertaken jointly by groups of CAMHS staff, and weekly telephone conferences between involved staff members and a nominated child protection worker were used to update on progress and arrangements for subsequent assessments and visits. Staff debriefing occurred following particularly difficult events.

Conclusions

Comprehensive assessment of 10 families referred to CAMHS from a remote IRPC identified a population with very high levels of psychopathology and distress, comparable with the research sample described by Steel et al.¹⁴ although methods of sampling and assessment differ. Treatment planning and intervention were

substantially unsuccessful for complex political and administrative reasons. Staff had no power to implement therapeutic recommendations, yet were responsible for providing a service to these families who they saw deteriorate over time.

Public health implications

The authors believe, in accordance with statements made by other professional bodies,²⁴ that health professionals have an ethical duty to care for patients regardless of citizenship or visa status and that all people have a right to adequate health and mental health services, regardless of their citizenship or visa status. These principles are significantly compromised in the context of Australia's present immigration policy.

There are multiple obstacles to adequate mental health service provision to families in immigration detention. These arise because of their indeterminate immigration status, physical, social and cultural isolation, and the politicised climate within which their ongoing detention occurs. Splits in responsibility for service provision and decision making about their well-being and future also contribute and occur at the level of State and federal government, adult and child psychiatric services, health and child protection services and public and private organisations. These factors have a significant impact on involved clinicians and raise questions about their role in this context.

Is it appropriate to continue to offer assessment and attempt interventions (supportive or otherwise) in a context where clinical standards are compromised, clinically based recommendations have not been implemented, the detention context is identified as a major source of the distress, and service provision can be misused to argue that detainees are receiving adequate specialist mental health care? What responsibility do clinicians as individuals and as service providers have to these parents and children in need and at what point is advocacy at a social and political level justified, if not inevitable?

These questions persist while mandatory indefinite detention of all unauthorised arrivals remains a central plank of Australian immigration policy and law. The infants, children and adults described live on our soil but outside the structures that protect citizens from dehumanising indefinite incarceration, ongoing traumatisation and, particularly for children, exposure to violence in a developmentally impoverished environment.

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