THE HEALTH OF CHILDREN IN IMMIGRATION DETENTION: HOW DOES AUSTRALIA COMPARE?

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ACKNOWLEDGEMENTS

During this work, LS was supported by the National Health and Medical Research Council of Australia Public Health Postdoctoral Fellowship Number 997096; National Health and Medical Research Council of Australia Travelling Fellowship Grant ID 235610. Special thanks go to everyone in the Refugee Services of Danish Red Cross, Icelandic Red Cross and Icelandic International Development Agency for their help and support.

ABSTRACT

We live in an age when the number of refugees worldwide is increasing. All of them have suffered physically or emotionally to a varying degree in their country of origin. The transit to a country of resettlement is fraught with further difficulties, or the risk of death. This article explores the different approach taken to the management of this issue by Denmark and Iceland, in comparison to that of Australia. In particular, the different approaches to health care for children and their families are identified. The management of these issues by Denmark and Iceland would appear to be a model to follow. Outcomes of the different managements have not been assessed.

INTRODUCTION

A refugee is defined as 'someone outside his or her own country and unable to return as a result of a well-founded fear of persecution on grounds of race, religion, nationality, political opinion or membership of a social group'[1].

While the number of asylum seeker children in Australia fluctuates, the number of people leaving their home countries to seek shelter in others is increasing worldwide. In 1991, 14,916,498 people were 'of concern' to the United Nations High Commissioner for Refugees (UNHCR), by 2002 the figure had grown to 19,783,100[2]. It must therefore be anticipated that there will continue to be a flow of refugees entering Australia who have suffered long term hardship in refugee camps around the world before being granted asylum.

Guidelines for the assessment and treatment of refugee children and their families could be drawn from strategies implemented in countries other than Australia. Denmark and Iceland accept four times the number of refugees per head of population as Australia. During a visit to the Nordic countries in 2002, the first author (LS) visited refugee centres in Denmark and Iceland to investigate ways in which the health needs of refugee/asylum seeker children were met and to ascertain differences in assessment and treatment between the Nordic countries' systems and those in place in Australia. This paper outlines the refugee situation in Australia, including how the health needs of children are met, and why particular problems arise in this paediatric population. It then discusses refugee positions and processes in Denmark and Iceland for all those who come to the countries seeking asylum and describes health services provided to children. Conclusions are drawn from examination of differences between the two Nordic countries and Australia.

BACKGROUND

Paediatric health care is different in substance and approach to that of adults; this is as true for child refugees as for any other children. Furthermore children of different ages are likely to be susceptible to different medical and psychological conditions and to require different methods of treatment. Assessment and intervention with refugee children is crucial as the risk for many chronic conditions, including heart disease and diabetes[3], depression[4], school failure[5,6] and adverse social outcomes such as delinquency, violence, marital instability and unemployment is set in place in early life[7]. Childhood is therefore a critical and vulnerable stage when poor socioeconomic, psychosocial or health circumstances, such as those experienced by refugees, can have lasting effects and long-term high cost to health and education services[5,8,9,10,11]. An increasing body of evidence shows that social factors strongly influence, developmental, educational behavioural and health outcomes for children[12,13,14]. Whilst there is tacit agreement that children's health and development is inextricably entwined with the psychosocial environment in which they live, these issues are frequently ignored in the assessment of children's needs and the provision of services. Children are dependent upon parents or care providers for access to health, education and other services[15]. When parents' ability to care optimally for their children is compromised by their own distress or through disempowering circumstances, this can be expected to impact upon the health and wellbeing of the children. A comprehensive and multidisciplinary biopsychosocial approach to health must therefore be adopted if health services to this marginalised cohort of people are to be effective[16].

The right to health care for refugee families and children is an integral part of the United Nations (UN) Convention on the Rights of the Child[17] and the

International Covenant on Economic, Social, and Cultural Rights[18]. Planning prospective health care is more efficient than trying to create programs once a condition arises. Such pro-active health care requires that fundamental issues such as selection and adaptation of appropriate assessment measures, and development of a standard assessment protocol be addressed. Only when these have been resolved will it be possible to systematically collect data on the health of this heterogeneous population which will identify their needs and permit development of suitable health services.

Seeking asylum in Australia

Refugees to Australia arrive via a number of different routes. A range of visa types is issued, granting a variety of rights. Child refugees may be accompanied by parents, or be unaccompanied. Refugees, adults or children, who arrive as part of the Australian Government's humanitarian programme are granted permanent residency status and rights to all services available to other residents, while those arriving on other visas (such as visitor visas) may apply for refugee status and the right to remain in Australia. While applications are processed, applicants have rights to limited services. Regardless of age, those who arrive without visas are routinely detained in detention centres within Australia whilst their refugee status is determined. Such individuals or families will at best be granted Temporary Protection Visas (TPV), even when their status as refugees has been accepted[19]. This permits residency in Australia for a period of three years, after which their status is again reviewed. Access to services such as health and education are restricted during this time and there are no provisions for family reunification.

Entitlements for refugees in Australia

Table 1 about here

Table 1 summarises entitlements for refugees in Australia. Refugees with permanent protection visas are entitled to a range of settlement assistance and support services, including access to employment programmes, work rights, Medicare, torture and trauma counselling, English language classes, schooling, Higher Education Contribution Scheme eligibility, permanent residence, family reunion, the right to return if they travel overseas, and social security benefits[19]. Refugees with TPVs have much more limited entitlements. They have temporary residence and work rights, but are ineligible for English language classes (lack of English can severely restrict employment opportunities). They can access Medicare, schooling, and counselling, but only limited employment assistance and income support, few settlement services, no family reunification, no rights to leave and return to Australia and access to tertiary education only at overseas students rates[19].

Asylum seekers with bridging visas granted whilst application for refugee status is considered are ineligible for employment assistance and for social security benefits. They are not entitled to English language classes, schooling, tertiary education, counselling or settlement assistance, and are ineligible to return should they travel overseas. They may be eligible to work and receive Medicare benefits but only if they follow correct procedures regarding applying for asylum within 45 days of arrival (many are uninformed about this timeframe). These policies have obvious implications for physical and mental wellbeing. Thus refugees differ in terms of their status under Australian law, socio-economic, educational, cultural and religious

backgrounds, history of persecution, and access to community resources and supports, and are consequently likely to have health care needs which are specific to their group and which differ amongst groups[20,21].

Refugees in Denmark

In 2001, Denmark had 12,512 applications for asylum[22] of which 9,972 were in the care of the Danish Red Cross (DRC). Two thousand, nine hundred and ten were children aged less than 18 years and of those, 308 were unaccompanied. Table 2 shows places of origin[23]. The DRC cares for the great majority of those who seek asylum in Denmark; the remainder are accommodated in two centres run by other organisations.

On arrival, a request for legal asylum is lodged with the police and people are sent to a holding centre for new arrivals. Within two weeks they have an initial interview with the Immigration Bureau and are then transferred to other centres where they live until immigration decisions are finalised. . If applications are successful, refugees are settled in the community, provided with housing and employment permits and given the same rights as all Danes. Unsuccessful applications are subject to appeal through the courts, and subsequently the immigration ministry. If they are still unsuccessful, applicants are returned their country of origin. The average time in a refugee centre is 17 months. Refugees from Kosovo provide an exception, waiting an average of 26 months because of their status under a specific program implemented after the 1999 Balkans War.

Denmark is a signatory to the United Nations Convention on Refugees[24]. Onus of proof of refugee status rests with the individual, but the Danish government provides legal assistance. Priority for admission to Denmark is given to those whose

health is compromised, the handicapped, or those with handicapped children. While most asylum seekers live in refugee centres, those with long waiting periods or who have special needs (10%) are housed in Immigration Department flats and houses, where they are supported by specially trained community health and welfare staff.

All but one of the refugee centres are open and people have freedom of movement and the right to leave the centre as required providing they sleep at the centre at night, and acknowledge it as their permanent address. Consequently, refugees can participate in local communities and, once they learn Danish, can leave the centre to participate in work practice schemes. In nine of the ten centres, families are provided with flats in which they are able to cook for themselves. One centre which is run by the Danish prison service is a detention centre and is reserved for refugee applicants who break the law or create problems.

All children in Denmark, including refugees and asylum seekers, are entitled to equal rights and level of community support. Children attend kindergarten from three to six years; schooling is compulsory from seven to 16 years. Each refugee centre has a school where lessons are usually in Danish, with interpreters available, while in some, children are taught in their own language. Classes are often taught in a mix of languages. Curricula are adapted to children's length of stay in the centre and developmental and education stages. As with all Danish children, asylum seeker children receive individual attention and special schooling as required. Training is provided for school staff about special needs and learning difficulties of refugee children, and the special needs program is the same as that available to Danish children.

Terminology surrounding asylum seekers is carefully chosen in Denmark and contrasts strongly with Australia. All asylum seekers are regarded as 'legal' (unless

they break Danish law). In Australia, all those who arrive without going through the formal application process prior to arrival are considered ‘illegal’.

Only a small number of refugees in Denmark are considered “illegal” and they are those who require detention and are held at the one centre run by the prison service. Individuals held in detention include those whose applications have been unsuccessful and who are awaiting deportation, those with serious mental illness and who pose a risk to themselves and/or others and those who have been violent or have broken Danish law.

Refugees in Iceland

Iceland lies just below the Arctic Circle in the middle of the North Atlantic Ocean. Approximately half the population of 279,000 lives in the capital, Reykjavík[25]. The most sparsely populated country in Europe with an average of about seven inhabitants per square mile, Iceland has a particularly close-knit community which experiences no unemployment and little crime. The isolation, rugged terrain, small size, booming economy and unique sociology of Iceland afford the opportunity for implementation of a progressive refugee system.

Refugee numbers have increased steadily from 1987 (Table 3). Most refugees to Iceland now come from Eastern Europe and the Middle East, with some from ex-Soviet states. When the movement of refugees to Iceland began, responsibility for their care was delegated to Icelandic Red Cross (IRC), however, in 1999, the government agreed to consolidate refugee policy. Currently the government holds legal responsibility for refugees and provides money and shelter for the long term, while IRC provides funding for the first three months[23].

Because Iceland is small, and remote, with a small population, a pro-active refugee programme could be put in place. One community per year hosts a refugee group and its local government is responsible for health, schooling and provision of services. A community manager employed by IRC facilitates meetings with community members and service providers. Preparation courses for community members include information about refugee life, circumstances, refugee health and other topics, including information about psychological trauma at all ages. Icelandic families who look after refugee families are supported with extra information, guidelines and education. These host families are the refugees' guides into Icelandic society, and there are two to three support families for each refugee family. IRC provides independent interpreters and arbitrates disputes. Refugees can work after five weeks and in time are encouraged to buy a home or apartment. Classes in Icelandic language and culture are held, as language proficiency is a requirement for citizenship for which refugees may apply after five years. Community housing is provided to all asylum seekers and refugees. Immigration decisions can take up to one year; during that time, people have no rights to the state run free education, health and other services enjoyed by Icelanders. However, these services are routinely provided by IRC. Iceland has no unemployment and this may be an influencing factor of the widespread acceptance of refugees.

Similarly to the formal refugee programmes in Australia, where people are brought from other countries according to Australia's need, Iceland has resettlement programmes, as distinct from those for asylum seekers. The IRC has an agreement with the government to visit refugee camps in other countries to choose candidates according to skills need. However, the programmes for community acceptance and assimilation into Icelandic society are the same as for asylum seekers.

HEALTH CARE

Health issues of refugees

Refugees suffer from a broad range of physical and psychiatric disorders. Chronic diseases and conditions associated with malnutrition are common as are injuries resulting from war, accidents and torture[26]. Over one third suffer symptoms of anxiety (including panic attacks, agoraphobia), with similar numbers complaining of significant symptoms of depression. Mental illness in this vulnerable population is frequently due to a combination of past experiences and current social circumstance. More than 20% of asylum seekers in Australia reported experiencing torture, with a third reporting imprisonment for political reasons, and a similar number reporting murder of family or friends[27]. Posttraumatic stress disorder (PTSD) is common, with some studies reporting up to 100% of refugees in specific ethnic groups suffering significant symptoms[28]. However, little is known about the aetiology, assessment and management of psychiatric illness in the child and adolescent refugee population, and of the long-term complications that may arise in these populations should appropriate interventions be unavailable. Refugee children have frequently been exposed to hardship, torture, trauma and death of loved ones, often with relatively little support from parents who are either absent or too traumatised themselves to buffer the effects of these experiences[29],[30]. The few studies undertaken in this area have reported high levels of emotional and behavioural problems, and a significant incidence of psychiatric illness, particularly depression and PTSD[31],[32],[33],[34].

Health services for asylum-seekers in Australia

In the six mandatory detention centres, general centre management and health services until very recently were contracted to a private company, Australian Correctional Services, a subsidiary of the American Wackenhut corporation, but this has now been taken over by the international security organisation Group 4 Falck, which also is linked to Wackenhut[35]. On-site nurses and visiting medical practitioners provide services which include initial health screening, a designated medical room, regular attendance by on-site or visiting medical officers, and referral to specialist services[36]. Few specialist paediatric services are provided. An evaluation conducted by the Human Rights and Equal Opportunity Commission[37] (HREOC) in 1999 identified health service delivery problems that included inadequate medical facilities and services, unreasonable expectations of medical services by detainees, poor attention by staff to cultural issues that determined the ways in which health issues were perceived and communicated, and, frequently, low education levels among detainees that led to poor understanding of health and health services. While HREOC drew attention to the lack of requirement, in all but one centre, for mental health qualifications for nurses, its evaluation did not make reference to lack of specialist paediatric services and appropriately qualified staff.

Health services for refugees in Denmark

A nurse who can make referrals for further screening if deemed necessary initially assesses the mental and physical wellbeing of new arrivals. This can include screening for diseases such as tuberculosis, HIV/AIDS, hepatitis, malaria and others. Mental health nurses and psychologists conduct mental health screenings. People with health problems are referred to appropriate State run services[23].

The primary focus of the health services conducted by the DRC is assessment and prevention or early detection and treatment of both psychological and physical problems. Health systems within centres are similar to those in the wider community and are led by qualified nurse practitioners who refer patients for appropriate treatment. All refugees are allowed to access the Danish health system and are seen by specialist services within the same time frame as Danes with similar conditions. On-site, trained interpreters are usually available to assist health care staff and telephone interpretation is used as required.

All centres employ qualified specialist public health , acute care and paediatric nurses. Specific on-going education programmes are provided for all staff, and counselling from psychologists and social workers with special expertise in refugee work is provided for all staff members, with a particular programme in place for teams who work with unaccompanied children.

Primary health care is a cornerstone of the Danish health services and children are screened regularly throughout their lives. Refugee children who arrive in Denmark are eligible for the same health services as Danish children. Their initial health assessment includes a broad range of physical examinations and most are found to be physically fit. Their mental health can however be at risk[38] and they are extensively screened for psychological disorders and psychiatric conditions, particularly PTSD. Reporting of child abuse/neglect is mandatory for all health and refugee professionals and a team of specialist child protection social workers and counsellors are available to deal with child protection issues.

All centres employ qualified child health nurses who have recourse to paediatric psychiatrists and psychologists. The nurses use stories to encourage children to talk about how they reacted to life in their home countries, any trauma

encountered, and how they coped. Regular meetings are held between refugee families and staff, and strategies for mastering of situations are taught in groups. Nurses and teachers educate parents about how children react to various situations and subsequent treatment and support is jointly planned. Meetings include an emphasis on physical exercise and drawing and painting has proven invaluable for enabling children to express their feelings.

Four principles guide treatment for the children: (a) sharing experiences, (b) encouraging them to describe experiences, either orally or by drawing and painting, (c) sharing techniques on how to cope, (d) supporting and encouraging adult co-operation. The emphasis in the centres is on prevention of physical and mental ill health and staff are quick to assess and recognise symptoms of PTSD or any other disturbance so that early intervention can be implemented for parents and children to prevent escalation of conditions.

Health services for refugees in Iceland

When Iceland began taking asylum seekers, most were men but in 2000, families began to arrive, and this trend has continued[23]. Health services for the children in these families are the same as for Icelandic children and no special health services are provided for refugees. Cases of PTSD, depression, or child protection issues in children or adults are recognised during the course of routine health screenings and treatment and support, either physical, social or psychological, provided.

On arrival, health assessment includes screening for tuberculosis and blood-borne diseases. This is done in community health centres[39], and one qualified paediatrician screens all children. The same screening routines used for Icelandic

children are used for refugee children, and once they enter school/pre-school, they receive the same health care. The refugee system in Iceland is conducive to the maintenance of optimum mental health of refugees, and the particular social situation surrounding the system facilitates this.

Conclusions

In the context of asylum seeker/refugee status in Australia, the following conclusions can be drawn:

- Philosophical and moral issues surrounding asylum seekers are the same for all countries.
- Denmark and Iceland accept proportionately more asylum seekers than Australia.
- Denmark, Iceland and Australia differ in the way refugee and detention centres function. Australia's policy of mandatory incarceration is in direct contrast to the Nordic policy of allowing people freedom of movement in and out of the refugee centres and communities.
- The excellent paediatric health care services to asylum seeker children in Denmark and Iceland are congruent with standards of preventive and curative health care given to all children in those countries.
- Family-centred care is extensively used in the Nordic countries as a basis for care in paediatric health services. Family-centred care ensures health care is planned around the whole family, not just individual members who require health care, and this model could be effectively applied in Australian centres
- In both Denmark and Iceland refugee health services are led by highly qualified nurses, and paediatric health care services are provided by specialist qualified paediatric nurses. This is in stark contrast to Australian centres where nurses in

charge of health facilities are sometimes qualified in psychiatric nursing but not in paediatrics. This lack of dedicated paediatric services is partly due to the remoteness of some of the detention centres, and the consequent difficulty of enticing suitably qualified staff to work in such desolate locations. However, given the large proportion of asylum seekers who are children (some of whom are unaccompanied) and the highly specialised knowledge required to nurse these children who are at high risk of psychological trauma, special consideration should be given to the recruitment of more paediatric nurses.

We argue that Australia's policy of mandatory detention must be reviewed. There is no evidence to suggest that in the Nordic countries, refugees cause increased crime rates or a decline in health service standards, or have a negative influence on society. Refugee children have special needs. Mandatory detention, which contravenes the UN Convention on the Rights of the Child[17] (to which Australia is a signatory) can do nothing but increase their suffering. This, in turn, will aggravate existing health issues and cause long-term ill effects with concomitant cost to the wider community as they grow into adults. Denmark and Iceland provide useful models for the health care of refugee children. We conclude that Australia would do well to implement, for all refugee children, regardless of their immigration status, equitable and appropriate paediatric health services that are delivered by qualified paediatric health professionals. The High Court of Australia in June 2003 declared that asylum seeker children can no longer be detained[40]. Implementation of this decree may provide a catalyst for review of health services to these children.

Table 1: summary of entitlements for asylum seekers and refugees in Australia

	TPV	Bridging Visa -45 days*	Bridging Visa +45 days*
Work rights	YES	YES (but no job search)	NO
English classes	NO	NO	NO
Family reunion	NO	NO	NO
Income support	Some	NO	NO
Health Assessment and intervention	NO	NO	NO
Medicare	YES	YES	NO
Residency	Temporary May apply for PR after 3 years	NO	NO
Settlement services	NO	NO	NO
School education	YES	NO	NO
Tertiary Education	Full fees	Full fees	Full fees
Torture & Trauma Counselling	Some	NO	NO
Travel & return to Aus.	NO	NO	NO

If a person arrives in Australia seeking asylum, application must be made with the appropriate authorities within 45 days of arrival. Applicants who submit after that time are considered illegal. This is not widely publicised and few arrivals know of this rule.

Table 2. Countries of origin of asylum seekers in care of Danish Red Cross 2001.

Nationality	**%**
Iraq	20
Kosovo	13
Afghanistan	13
Serbia	12
Bosnia-Herzegovina	5
Armenia	4
Iran	4
Somalia	4
Slovakia	3
India	2
Other places	20

Table 3. Numbers of those seeking asylum in Iceland, 1997-2002.

year	Numbers
1997	19
1998	17
1999	24
2001	52
2002	88 (by September)

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