

Mental health screening in immigration detention: A fresh look at Australian government data

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Peter Young Sydney, NSW, Australia

Michael S Gordon Adjunct Clinical Associate Professor, Monash University, Melbourne, VIC, Australia

Abstract

Objectives: The poor mental health of asylum seekers and refugees in immigration detention has consistently been reported in peer-reviewed literature internationally; however, data on the mental health of asylum seekers and refugees detained in Australian immigration has been very limited.

Methods: We re-analysed mental health screening data obtained by the Human Rights Commission.

Results: Longer time in detention was associated with higher self-reported depression scores, with female individuals being more vulnerable to time in detention than those of male gender. Approximately one-half of the refugee group who agreed to complete the Harvard Trauma Questionnaire had post-traumatic stress disorder symptoms. On clinician-rated measures, one-third of the children, adolescents and adults suffered with clinical symptoms requiring tertiary outpatient assessment.

Conclusions: This paper consolidates the findings of the 2014 Australian Human Rights Commission report and it provides an argument for public reporting of refugee data.

Keywords: Australian Human Rights Commission, detention, Harvard Trauma Questionnaire, immigration, refugees, mental health, mental health screening, post-traumatic stress disorder, refugees, stress, time

Refugees and asylum-seekers in detention are a very vulnerable group, given their histories of complex trauma arising in their country of origin, experience of treacherous journeys across hostile countries by unsafe means, leaving vulnerable family in their home country, financial and material loss, loss of identity, insecure waiting times and the conditions in detention¹. Whilst in prolonged detention, a climate of powerlessness, self-blame, despair and distress leading to self-harm and rioting have been described as adding to their psychological burden². Treatment options to address the refugees' mental and physical needs are limited.

Refugees suffer with a number of mental health problems, including suicidal thinking and behaviours, anxiety, post-traumatic stress disorder (PTSD) and depression^{1–4}. Tortured refugees or displaced people suffer with PTSD at rates between 14–92%³. While the adjusted prevalence of depression in refugee populations has been found to be 30.8% in a meta-analysis of 117 studies, depression in refugee populations is reported to be as high as 85.5%⁴. Increased time spent in a detention centre is associated with deterioration in mental health, for adults and children^{5,6}.

Although policies for screening and monitoring the mental health of people in immigration detention commenced in 2009, by 2011 the implementation was still partial, patchy and inconsistent. In 2011, basic clinical assessments were being conducted when people entered detention, but there were no mechanisms to monitor their quality or completeness. The first author, then working as Director of Mental Health Services for International Health and Medical Services (IHMS), undertook a program to progress the implementation of the screening program and to update the screening instruments; to align these to the standard instruments, processes and reporting practices established for public mental health services in Australia⁷.

Following a consultative process between IHMS and the Detention Health Advisory Group (DeHAG), a semi-independent health advisory group to the then Department of Immigration, Multicultural and Indigenous Affairs

Corresponding author:

Michael S Gordon, Monash University, 246 Clayton Road, Clayton, Melbourne, VIC 3168, Australia.
Email: Michael.Gordon@southernhealth.org.au

(DIMIA); had reached an agreement to change the screening instruments. These instruments, for adults, became the clinician-rated Health of the Nation Outcome Scores (HoNOS), the self-rated Kessler 10 (K-10) and the Harvard Trauma Questionnaire (HTQ); and separately for use in children and adolescents, the clinician-rated Health of the Nation Child and Adolescent Outcome Scores (HoNOSCA).

In May 2014, following the Department of Immigration and Border Protection's (DIBP) receipt of the latest set of quarterly screening figures, the department advised that the reporting of screening results should cease, pending review by its medical advisors.

The Australian Human Rights Commission compelled DIBP to release some of this data in the conduct of its 2014 inquiry into children in detention⁸. This de-identified data was obtained by a Freedom Of Information (FOI) application, and released under the Office of the Australian Information Commissioner's guidelines, as meeting the 'Public Interest Test'⁹. This data set is now on the public record; and it is available without an application to a human research and ethics committee¹⁰.

Although the majority of people described in these results were detained asylum-seekers, the data does not distinguish between asylum seekers, refugees and others. We describe our cohort, for the purposes of consistency and economy, as detainees.

From the available research, we generated three hypotheses:

1. The female detainees would have higher HoNOS, HTQ and K10 scores than the males.
2. A longer time in detention would predict higher K10 scores.
3. A large proportion of the detainee children and adults would have elevated HoNOSCA and HoNOS scores, respectively, when compared with a clinical population in mainland Australia.

Methods

In Australia, people entering immigration detention are screened within 10–30 days of detention. The screening consists of a standard clinical assessment, the HoNOSCA for children and adolescents¹¹; and separately, HoNOS¹² and K-10¹³ for adults. The HTQ is offered to persons whom report a history of torture or trauma; or in whom this is suspected, at their initial screening¹⁴.

Screening is conducted by mental health nurses or psychologists, whom have completed the Australian Mental Health Outcomes and Classification Network (AMHOCN) training module for HoNOSCA and HoNOS¹⁵. Scheduled screening reviews are completed after 6 months in detention; then at 12 months and thereafter, every 3 months. At 18 months in detention, there is a scheduled clinical assessment by a psychiatrist.

Scores of ≥ 30 on the K-10 are associated with a very high risk of a depressive or anxiety disorder¹⁶. The cut-off

scores for the HTQ for PTSD are reported to be ≥ 2.5 ¹⁴ and separately, as reported by Oruc et al.¹⁷, > 2.06 .

Statistical analysis

Descriptive analyses were conducted. The symptom and outcome measures (HoNOS and HoNOSCA) were compared to the summary ambulatory data available on the AMHOCN⁷. T-tests were conducted between HoNOS results and data from AMHOCN; and separately, HoNOSCA scores and data from AMHOCN. Satterthwaite's approximation was used in the event of unequal variances. Linear regression analyses were conducted using K-10 scores as the dependent variable; and time in detention (in weeks), gender and age grouping as the independent variables. The data was analysed using Stata 12¹⁸.

Results

The screening results were related to the children, adolescents and adults held at 25 Australian-run detention centres, excluding those in Papua New Guinea and Nauru. The total number of detainees who were subject to screening during the study period is not available however, but an estimate can be made from monthly census figures published by DIBP which show that in January 2014 there were 3939 men, 922 women and 1006 children in detention¹⁹. In June 2014 these figures were 2326, 599 and 699 respectively²⁰.

K-10

Between February to June 2014, 1384 detainees were assessed using the K-10 (Table 1). Female detainees had significantly higher K10 scores than their male counterparts ($p = 0.017$). The results contain a small number of scores from children and adolescents < 16 years old (18 detainees were ≤ 17 years). This represents non-adherence to the screening procedure, as K-10 should only be used for subjects aged 16 years and over. Of the 1384 detainees, 103 (30 female detainees and 73 male detainees) had a K-10 score of 30 or more.

For those detainees who were scored on the K10, the mean time in detention from arrival to the K10 assessment was 49.84 weeks (SD 39.16). In a linear regression, the time in detention (coefficient = 0.036; $p < 0.001$) and gender (coefficient = -1.67 ; $p = 0.002$), but not age, predicted the K10 scores. The K10 score is estimated to be 0.036 points higher per week of detention ($p < .001$). Male detainees had K10 scores that were lower by 1.7 points ($p < 0.01$) than female detainees, on average. There was no evidence that the K10 score was associated with age.

HTQ

From January to June 2014, there were 215 detainees who completed the HTQ. Of this cohort, 119 detainees were female and 132 detainees were male (Table 1). On the *t*-test, there was a significant difference between these male and

Table 1. Summary table for the total score numbers of K-10, HTQ, HoNOS and HoNOSCA tests

Measure	Subjects (total and by gender)	n	Mean (SD)	Time in detention (mean weeks, SD)	AMHOCN ⁷ (n) (mean, SD)
K10	Total	1384	16.64 (7.76)	49.84 (39.16)	20,862; 25.8; 9.1
	M	1142	16.37 (7.4)	51.20 (41.59)	
	F	242	17.88 (9.2)	43.38 (23.68)	
HTQ	Total	251	2.15 (0.83)	N/A	N/A
	M	132	1.94 (0.81)	N/A	
	F	119	2.37 (0.81)	N/A	
HoNOS	Total	758	5.17 (4.85)	N/A	101,046; 11.5; 6.1
	M	520	5.42 (4.71)	N/A	
	F	238	4.61 (5.11)	N/A	
HoNOSCA	Total	243	6.03 (7.38)	N/A	43,187; 14.6; 6.8
	M	141	5.6 (6.62)	N/A	
	F	102	6.63 (8.32)	N/A	

AMHOCN: Australian Mental Health Outcomes and Classification Network; F: female gender; HoNOS: Health of the Nation Outcomes Scales; HoNOSCA: Health of the Nation Outcome Scales Child and Adolescent; HTQ: Harvard Trauma Questionnaire; K-10: Kessler 10 mental test; M: male gender; N/A: not available.

female detainees' scores ($p < 0.001$), suggesting that female detainees suffered with higher levels of trauma/PTSD than the male detainees. Using the HTQ, 44.2% (111/251) of the detainees had scores ≥ 2.5 ; while in Oruc et al.¹⁷, a cut-off of > 2.06 shows that 53.8% (76 female detainees and 59 male detainees) of those surveyed met the criteria for PTSD.

HoNOS

For this study, 758 adults had complete HoNOS scores (Table 1). Those of male gender had a significantly higher HoNOS score than female detainees, on the *t*-test ($p = 0.033$). The summary comparison data provided on the AMHOCN website (1 July 2011 to 30 June 2014) was reported in Table 1⁷. Compared to the summary data provided by the AMHOCN website, there were 212 (30%) refugees sampled whom had HoNOS scores that were greater than the average score required for service in the public mental health services (Figure 1).

HoNOSCA

We had 243 children and adolescents aged 5–17 complete the HoNOSCA (Table 1). The summary comparison data provided on the AMHOCN website is reported in Table 1. Compared to the summary data provided by the AMHOCN website, 34.16% (83/243) of the refugee children and adolescents had a comparable mean HoNOSCA of 14.36 (SD 6.7), i.e. the scores were greater than the average score required for service in the public mental health services. This means that the average HoNOSCA scores of the most unwell 83 detainee children and adolescents was statistically indistinguishable by *t*-test from the average scores of

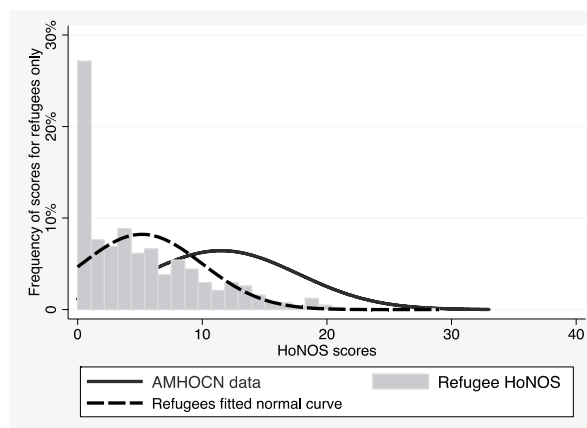


Figure 1. Histogram of the refugee HoNOS scores, with fitted normal curve and overlaid AMHOCN normal distribution curve.

AMHOCN: Australian Mental Health Outcomes and Classification Network; HoNOS: Health of the Nation Outcomes Scales

children and adolescents whom were accepted for outpatient assessment at the Australian Child and Adolescent Mental Health Services (CAMHS) (Figure 2).

Discussion

Consistent with the Human Rights Commission's report⁸, a longer time in detention was associated with higher self-reported depression scores. We found that on the K-10, female detainees were more vulnerable to time in detention

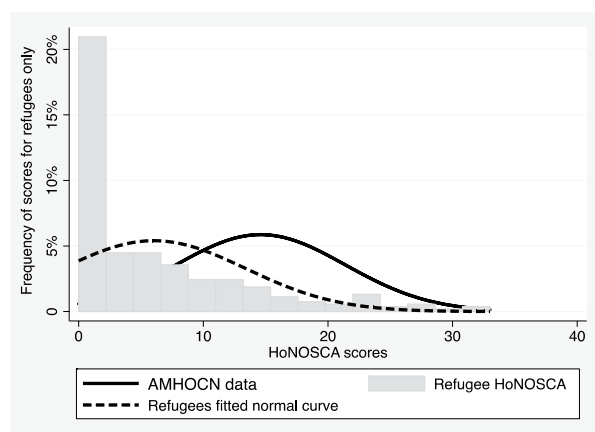


Figure 2. Histogram of the refugee HoNOSCA scores, with fitted normal curve and overlaid AMHOCN normal distribution curve.

AMHOCN: Australian Mental Health Outcomes Classification Network; HoNOSCA: Health of the Nation Outcome Scales Child and Adolescent

than male detainees. Approximately one-half of the refugee group who agreed to complete the HTQ had PTSD symptoms, and one-third of the children, adolescents and adults had clinical symptoms requiring tertiary outpatient assessment, based on the HoNOSCA and HoNOS scores. These results are consistent with previous research related to mental health of refugees and asylum seekers^{1,3,4}.

It should be noted that there are several limitations of these results. We were constrained in only being able to analyse the data as provided. Data enabling longitudinal analysis was not made available, so results are cross-sectional only. The K-10 and HTQ are self-reported measures. The literature suggests that self-reported measures lead to 10% higher levels of PTSD than by diagnostic interviews. The data does not distinguish between the asylum seekers and others in detention, such as people who have overstayed visas. Other useful demographic information (such as language, ethnicity and country of origin) was also excluded. The results are retrospective and may be affected by differences between the raters of HoNOS and HoNOSCA. The K-10 and HTQ scores may be affected by language and cultural issues, trust of the clinical staff and interpreters, and anticipated effects of disclosure on the responders' immigration outcome.

Given these findings and the report from the Human Rights Commission that prolonged detention causes harm to mental health⁸, it was surprising that the Department and the Australian Government refused to release data on the detainees held on the mainland and in offshore detention. There are several years of consecutive data that had been collected, but not released. Our results and the report from the Human Rights Commission provide an imperative for the release of longitudinal data on children, adolescents and adults in detention, for independent analysis. Also, we encourage interested researchers to obtain the full data set from the Australian Human Rights Commission

and to submit FOI applications for receipt of the up to date screening results that are held by the DIBP.

Disclosure

The authors report no conflict of interest. The authors alone are responsible for the content and writing of the paper.

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