

Mental health and deprivation of liberty: experience report as a psychiatrist in a refugee detention center

Saúde mental e restrição de liberdade: relato de experiência como médica psiquiatra em centro de detenção de refugiados

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ABSTRACT The experience report refers to the author's work, for six months, as a psychiatrist for Médecins Sans Frontières (Doctors Without Borders – MSF) in a refugee detention center in Nauru, an island country in Oceania. The report provides descriptions of the field work and theoretical reflections. The author discusses the issue of suicide and the specificity of such issue for the group of refugees and asylum seekers attended, as well as the discovery of a new clinical diagnosis called resignation syndrome. It's also sought to reflect on the role of mental health professionals in dealing with deprivation of liberty and discusses ethical challenges experienced in the field, regarding Australia's refugee policy, its economic importance to Nauru and the impact on the refugee population; obstacles encountered until MSF team was expelled by the local government on October 5th, 2018.

KEYWORDS Refugees. Mental health. Migration policy.

RESUMO O relato de experiência refere-se ao trabalho da autora, por seis meses, como psiquiatra por Médicos Sem Fronteiras (MSF) em centro de detenção de refugiados localizado em Nauru, um país insular da Oceania. O estudo traz descrições do trabalho de campo e reflexões teóricas. Discute-se a temática do suicídio e a especificidade dessa questão para o grupo de refugiados e solicitantes de asilo atendidos, assim como relata-se a descoberta de um novo diagnóstico clínico chamado síndrome de resignação. Busca-se ainda refletir sobre o papel dos profissionais de saúde mental diante de situações de privação de liberdade e discutem-se impasses éticos, vividos em campo, com relação à política de imigração australiana, sua importância econômica para Nauru e o impacto na população de refugiados; impasses esses vividos até a expulsão da equipe de MSF pelo governo local em 05 de outubro de 2018.

PALAVRAS-CHAVE Refugiados. Saúde mental. Política migratória.

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Introduction

The humanitarian organization Médecins Sans Frontières (MSF) has been operating since 1971; currently, it has projects in more than 70 countries around the world. MSF takes health care to contexts in which there are armed conflicts, epidemics, malnutrition, natural disasters and exclusion from access to medical assistance¹.

In 2017, MSF has started a project in Nauru, an island country located in Oceania. The lack of mental health support was identified for both the Nauru population and the refugees living on the island as part of the Australian government's offshore resettlement policy².

The MSF Nauru Project had its beginning in an agreement with the Nauru Ministry of Health, in which psychological and psychiatric services began at the end of 2017. After 11 months of work, in an abrupt turnaround, it was announced, in October 2018, that services would no longer be needed; and the entire MSF team was ordered to leave the island².

This experience report refers to the author's reflections on mental health, violence and deprivation of liberty issues, based on her experience as a member of the MSF's medical team for six months in Nauru. The author is a psychiatrist, dealing with adults, children and adolescents, a doctorate student in probationary phase at the Institute of Psychiatry of the Federal University of Rio de Janeiro (Ipub/UFRJ); and participated in the MSF Nauru Project from April 2nd, 2018 to October 3rd, 2018.

Located more precisely in the Oceania region called Micronesia, the island country has territorial extension of only 21 square kilometers, being the third smallest of the world. The nation is also one of the least populous, with about 10 thousand inhabitants. Nauru's economy is underdeveloped, based on the exploitation of phosphate reserves. However, with the near exhaustion

of reserves, Nauru has entered into an economic crisis. The Gross Domestic Product (GDP) of the Country was one of the biggest in the world in the 1970s. At the present time, with few growing areas, it is forced to import most foods³.

Nauru and Australia have a long and uncomfortable political history. Australia was the administrative power and main beneficiary of phosphate mining in Nauru between 1920 and 1968, during which about 34 million tons of phosphate were removed, amounting to about US\$ 300 million⁴. After years of exploitation, the mined areas cover almost 90% of Nauru; and its rehabilitation has been extremely expensive and slow. The Environmental Vulnerability Index (produced by the Pacific Islands Applied Geoscience Commission) ranks Nauru as 'extremely vulnerable'⁴. Such political-economic-environmental issues had impact on its economic sovereignty. The island country, as already mentioned, has entered into crisis; and Australia's offer to house an offshore refugee processing center has become the main source of financial resources for Nauru. It should be clarified that the offshore term means away from the coast, and is used to describe jobs on the high seas. With respect to refugees and asylum seekers issue, the term is used when there are resettlements in remote places, on the high seas, such as in Nauru.

The said center was opened in 2001, suspended in 2008 and reopened in 2012, after an increase in the arrival of asylum seekers in Australia. As exposed by Lowth⁵⁽⁴⁶⁵⁾

In 2013, desperate to curb arrivals by sea, Australia declared that no asylum seeker arriving by boat would ever settle on Australian soil. Instead, they are sent for 'offshore processing' at detention centres on Nauru and Manus Island. [...] Australia's actions contravene international treaties they have long since signed. There are around 1200 asylum seekers on Nauru and 900 on Manus Island,

from a variety of Middle Eastern, African, and Asian countries. Many are children and conditions are dreadful.

Data from the United Nations High Commissioner for Refugees (UNHCR) – an agency of the United Nations Organization (UNO) for Refugees –, from June 19th, 2018, reveal that 68.5 million people make forced displacement around the world, with 25.4 million refugees and 3.1 million asylum seekers⁶. Destination countries have been developing ever more restrictive measures to control who can enter and remain in their territory, including the detention of migrants. Although the detention policy of migrants should be non-punitive, they are kept under prison conditions, without visas and without relocation freedom. The impacts of this detention process on the mental health of refugees and asylum seekers have been researched.

Studies from around the world have consistently shown high levels of distress among asylum seekers in immigration detention [...] An Australian study found that, 3 years after release, asylum seekers who had been detained over 6 months were twice as likely to be clinically depressed (54 vs. 22%) and almost five times as likely to suffer from PTSD (49 vs. 10%)⁷⁽²⁾.

The author of this experience report acted as a psychiatrist serving about 30 to 38 refugees and asylum seekers from countries such as Iran, Afghanistan, Lebanon, Sri Lanka, Myanmar and Iraq, all with an average of five years of stay in Nauru. Mental health issues were intensely complex, as will be presented and discussed throughout the report. The author attended adults, children and adolescents in an outpatient model with individual consultations and home visits. In order to manage the language barriers, services were, often, accompanied by the interpreters who made up the MSF team.

When the interpreter was not required, the services were carried out in English only.

Experience report: context description

As set out in the MSF's 'International Activity Report' for the year 2017⁸, during the exploratory mission, mental health needs in Nauru were evaluated; and insufficient capacity to address them on the island was considered. Cases of schizophrenia, family violence and many levels of depression, especially among children, were identified.

The fieldwork reported here corresponds to the six-month mission period of the author in Nauru, begun in April 2018, when MSF had been in the field since November 2017. The actions carried out led to intense reflections on the effect of detention policies on the mental health of refugees and asylum seekers, as well as on the role of mental health services operating in these conditions.

The refugee patients spontaneously required consultations at the clinic set up by MSF, or were referenced by some other organizations also present in Nauru. Individual consultations were scheduled, or home visits, if the case met criteria such as limitation of locomotion, presence of young children in the family, hampering mobility, and severity of the case, impeding clinic visit. The average number of visits per week was 80 individual consultations⁸.

According to data collected, the author assisted about 60 refugee patients. In June 2018, there were 20 children and adolescents in assistance, of whom the author assisted 16 patients. The other ones were adults. The team at the clinic was composed of two psychiatrists, a psychologist, two cultural mediators, who performed the work of interpreters, a health promotion professional, a mental health manager, in addition to the logistics team and the field coordinator.

During the visits with refugee patients,

common issues could be perceived. Non-choice of being in Nauru, indefinite detention, producing a sense of life imprisonment, and awareness of the presence of the refugee center as the Country's main economic resource, contributing to the development of a strong sense of dehumanization and hopelessness. Another important element identified was that the absolute majority of the patients did not report mental health problems prior to their arrival in Nauru and referred to the development of these problems as a consequence of their forced stay in the Country. The author of this report heard significant testimonies, pointing out the fact that even experiences with combat situations, torture and killing of loved ones in the countries of origin, or during the migratory journey, caused less damage to the mental health conditions than living in Nauru.

The main mental health issues diagnosed were on the field of Major Depressive Disorder (MDD), Anxiety Disorder (AD) and Posttraumatic Stress Disorder (PTSD), following the diagnostic criteria of the 'Diagnostic and Statistical Manual of Mental Disorders', fifth edition (DSM-V). Cases of psychosis were seen among refugees in a rather small number. The cases of psychosis and schizophrenia as such were more frequent in the native population of Nauru, which was also assisted by the work in progress, but the focus of this report will be the actions with the refugee population.

The findings in Nauru are consistent with data from the literature on the effect of detention policies on the mental health of immigrants, as exposed above⁷. However, peculiar aspects have demonstrated to exacerbate the difficulties of adaptation of the refugee population, strongly impacting their psychic mechanisms of resilience. These are: the intense cultural difference, violations of human rights and repeated complaints of medical negligence, related to the other medical services of Nauru and present in the Country. These aspects intensely strengthened the sense of dehumanization experienced.

Among mental health issues, this report will focus on the theme of suicide and the diagnosis of resignation syndrome evaluated in four patients assisted.

Field work: main results found

Suicide, representations and contagion effect

During the complaint process in October 2018, after being asked to withdraw its teams from Nauru by the local government, MSF warned of an alarming number of suicide attempts among refugees. In the author's evaluation, the performance of the MSF's team with patients with suicidal intent, claiming an improvement in the assistance provided by other health services on the island, generated political tensions with the Nauru government. These tensions were intensified throughout the mission, culminating in the official request for the withdrawal of MSF from the Country on October 5th, 2018.

At least 78 of the patients attended by MSF had suicidal thoughts and/or carried out acts of self-mutilation or suicide. Children up to 9 years of age reported that they would rather die than live in the hopeless situation they were in⁹. Among the approximately 60 patients assisted by the author, there was one case of partial improvement, with diagnosis of major depressive disorder, according to DSM-V. All the other patients did not evolve with sustainable improvement and deepened or developed suicidal ideation.

The suicide issue was in everyday life in clinic or home visits. Attempts occurred regularly, leading the author and other members of the MSF team to accompany patients at the only local hospital and negotiate their admission into existing beds at a regional processing center, managed by the International Health Medical Services (IHMS) medical

organization. Studies on suicidal tendencies in detention centers are consistent with the findings in Nauru.

There is reason to believe that the conditions of the detention contribute significantly to the suicidality of the detainees, as reports (Amnesty International, 2012, 2013; Moss, 2015) show serious violations of human rights in off-shore detention centres. They signal asylum seekers lack access to adequate shelter, water or medical services; their access to phones or other means of contact is limited, which leads to isolation from family and friends, and the asylum seekers are left in uncertainty about the length of refugee status determination (Anistia Internacional, 2012, 2013)¹⁰⁽¹⁰⁷⁾.

The deterioration of the mental health conditions of the refugee patients assisted was remarkable throughout the six months of the author as a psychiatrist in Nauru. Patients had low or no response to the use of antidepressants (fluoxetine, sertraline and venlafaxine available), even when associated with regular psychotherapeutic treatment. Studies on suicide show that the issue has been discussed as a global public health problem. According to Durkheim (1982), cited by Müller, Pereira and Zanon¹¹, suicide can be defined as the death resulting from an act, positive or negative, produced with the knowledge of the consequences by the victim him/herself. In addition, according to Botega (2015), also cited by Müller, Pereira and Zanon¹¹, a model of susceptibility applies to the theme of suicide, including a genetic propensity, allied to psychosocial factors, demarcating elements such as childhood traumatic experiences, deprivation maternal, physical abuse, among others.

Data from the literature point to an exposure to multiple adversities as consistently influencing suicidal behavior. A relationship between the number of adversities experienced, especially in childhood, and suicide attempts throughout life has been raised¹². Patients refugees in Nauru consistently

reported traumatic events in their countries of origin and during the migratory journey, and were consistent with the literature on multiple adversities. The stay in Nauru, marked by uncertain detention, dehumanization and hopelessness, led the vast majority of patients to a retraumatization, making it impossible to elaborate previous traumatic experiences. Hopelessness was the guiding thread for suicidal ideation and suicide attempts. However, the author's listening exercise during the visits with reports of suicidal ideation, or acting in suicide acts in Nauru, made possible the understanding of a unique characteristic of the suicide for these refugees: suicide revealed as an act of re-empowerment. As Rimkeviciene et al.¹⁰⁽¹¹⁴⁾ reveal when analyzing the case of a refugee hospitalized in Australia after suicide intentions,

[...] The suicide thus became a way to reclaim the power over life decisions and the only way to escape the entrapment. Such feelings of entrapment are inherent in the prolonged, open-ended detention.

This characteristic of suicide, as power recovery, strongly impacted the author of this story. Arrested for five years in Nauru, refugee patients expressed, in the discussion about their own death, the only possibility of protest and assertion of some decision-making power over themselves. Such a formulation has brought important insights into what mental health treatment would be possible in front of it. How to produce impacts on the reduction of suicidal ideation and suicide attempts, when the suicidal act poses itself as the contradictory affirmation of power over one's own life? How to intervene in suicidal speech, when it reveals itself as opposition to the lived actions of dehumanization and violation of rights? These inquiries followed the author's fieldwork over six months and will be further explored below.

Another important element experienced was suicide as a contagion. Nauru, as described

above, is one of the smallest countries in the world, an island country, whose fence for the refugees who live there are the sea and the great corals of the Pacific Ocean. Studies point to evidence about the hypothesis of the suicide contagion effect, especially by the association between suicides exposure on media platforms, celebrity suicides, geographic grouping and impact on suicide rates¹³. Field experience has revealed the contagious power of the suicide act. The factors listed above were associated with determinant events, producing an increase in acts of self-mutilation with suicidal intent, acts of self-immobilization, excessive intake of medication and drowning attempt. Such determining events began after June 15th, 2018, when one of the refugees died in Nauru on suspicion of complete suicide and when medical transfers out of the country were contemplated for cases of serious suicide attempt.

Resignation Syndrome (RS): a new clinical experience

As described above, the author of this report attended children and adolescents as a child psychiatrist. Among the children and adolescents under treatment in the six months of the author's mission, of the 16 young people attended, 7 had medication prescription. The main diagnoses according to the DSM-V were PTSD in children, PTSD with psychotic characteristics, AD and MDD with suicidal ideation. The evolution of four cases led the author and the MSF team to the investigation and discovery of a diagnostic discussion not incorporated into the traditional DSM and International Code of Diseases (ICD) psychiatric manuals.

The patients addressed here, 1 boy and 3 girls, were 10 years, 12 years, 15 years and 18 years old. Nationalities shall not be divulged for the purpose of preserving confidentiality. The patients started the picture with depressive symptoms, evolving with suicidal ideation, episodes of psychomotor

agitation, alternating with stupor marked by hypotonicity. The continuity of the condition occurred with complete absence of responsiveness without reactivity to tactile or algetic stimuli and refusal to feed and liquids, culminating with the need for evaluation for nasogastric intubation.

The cases differed from a classic depressed stupor, since the complete absence of reactivity accompanied by hypotonicity referred to a comatose state. In research in the literature, in the encounter with studies carried out in Sweden, it was possible to correlate the experience lived in Nauru with the findings of such study.

Lagercrantz et al.¹⁴ describe and discuss a syndrome that encompasses a long-standing disorder, that predominantly affects children and adolescents, psychologically traumatized, in the midst of a time-consuming and adverse migration process. A depressive onset is followed by progressing social isolation, via stupor, to a state that induces tube feeding and is characterized by the inability to respond even to painful stimuli. Patients appear to be unconscious. The syndrome, denominated 'Resignation Syndrome (RS)', may be present in four stages: prodromal (anxiety, dysphoria, social isolation, sleep disorders), deterioration (mutism, absence of nonverbal communication), complete development (stupor, negativism, absence of reaction to stimuli, alimentary dependence by nasogastric intubation, hypotonicity, periods of excitability, weak reflex response to neurological examination, among others) and remission.

The study argues that RS remission tends to occur within months to years and is dependent on the restoration of hope for the family and the patient. From January 2013 to April 2015, 424 cases were identified exclusively in Sweden in a universe of 6,547 asylum applications from 0 to 17 years. This led the Swedish National Board for Health and Welfare to recognize RS as a separate diagnostic entity. The study points out, furthermore, the absence of reports of cases identified in other countries¹⁴.

In May 2018, data indicate that 939 refugees and asylum seekers still live in Nauru. Among these, about 27 children and their families remain in the Country with no hope of resettlement¹⁵. In this universe, the identification of four RS similar cases denotes a significant incidence. Other cases were also reported as being consistent with RS but attended by other health organizations present in Nauru. On the aetiological possibilities for such a condition, the study cited here¹⁴⁽⁴⁾ discusses:

An expert committee suggested six etiological conceptualizations. These included: (1) the medical model of disorder according to which a disorder affects vulnerable individuals under certain circumstances; (2) the family model stressing family psychology system theory; (3) the psychological model emphasizing effects of uncontrollability; (4) the political model identifying political decisions governing the asylum process; (5) the cultural model proposing the symptoms to instantiate a phenomenon belonging to either the patients' cultural, religious or existential descent or to that of the country to which they migrate. Implicit in the cultural model lays the notion of secondary illness gain; and (6) according to the intended model an intentional decision made by the family or by the child explains the symptoms.

Taking into consideration the varied aetiological pathways, in which medical, cultural and political models are intertwined, all those applicable to the cases attended, the challenges and bottlenecks for the construction of clinical interventions in a refugee center as in Nauru have proved to be a factor of tension for the technical team, generating intense reflections to be exposed later on.

Discussion

Dictionary research reveals the definition of concentration camp as a military confinement

center, installed in areas of free terrain and surrounded by barbed wire or other type of barrier. Its perimeter is constantly monitored and shelters prisoners of war and/or political prisoners. Although refugees and asylum seekers live in Nauru in settlements with containers for habitation, in relatively good physical condition of housing, having mobility across the island and the possibility of getting one of the few available jobs, or opening small businesses, lack of freedom of choice, with the sea as a fence, presence of guards in the settlements, numerous complaints of human rights violations and medical malpractice make it possible to describe the Refugee Centre of Nauru in a modernized concentration camp logic.

Many refugee patients referred to their stay in Nauru as a prison without a definite sentence. The cases attended were clearly marked by the consequences of deprivation of liberty, hopelessness and dehumanization. Goffman¹⁶ coined the concept of 'total institutions' as places of housing and work, for individuals with common situations, but separated from society and leading a life closed and administered by the institution. These characteristics are common to psychiatric hospitals, prisons, including concentration camps. Considering the experience in Nauru as being of 'total institution', it was up to us reflecting on serving as mental health professional in this context.

Jansen et al.¹⁷⁽¹⁾ problematize medical practice in refugee centers, discussing the notion of torture applied to these centers. The authors argue that detention, as Australian immigration policy, is torture and exploit the difficulties that doctors face when they act in that context.

Prolonged immigration detention causes anxiety, depression, post-traumatic stress disorder, self-harm and suicidal ideation. Furthermore, the risk of severe mental health harm increases with increasing time in detention. The United Nations and other definitions of psychological torture include severe psychological harm inflicted intentionally to

constrain or punish people for any reason based on discrimination of any kind by or with the consent of someone acting in an official capacity. Australia's policy of prolonged indefinite mandatory detention in order to discourage or punish people seeking asylum fulfils these definitions of psychological torture.

The complicity concept is also analyzed by Jansen et al.¹⁷ based on the studies of the humanitarian doctor Chiara Lepora and the philosopher Robert Goodin. Lepora and Goodin¹⁸ intertwine philosophy, law, political science and long practical humanitarian experience in conflict areas and lecture on different degrees of involvement with 'bad actions'. The authors argue that the main point is that, in the face of hideous situations, a degree of complicity may be acceptable. They further argue that there are circumstances in which being complicit in a harm, in the end, is the right thing to do.

It can be concluded that, during a large part of the mission, continuing to care for patients seemed the right thing to do. What is the goal of mental health treatment? Relief of suffering, reduction of symptoms, construction of humanized clinical acts before the ongoing dehumanization? At a first stage, these seemed the possible goals for the work accomplished. Performing at a minimum level of complicity, in the face of the psychological torture produced by the actions in the refugee detention center.

However, as discussed by Richter & Katschnig¹⁹⁽⁹⁷⁵⁾, "up to now, psychiatry is considered by sociologists as part of the mechanisms of power that are imposed by the State on its citizens" [free translation]. In the face of the incipient impact of the work carried out in the reduction of symptoms and, especially, in the face of the encounter with a dimension of suicide considered as 'empowerment' and the attendance of cases similar to RS, whose investigated study pointed to the restoration of hope as the most important intervention, the consideration that was imposed was on the possibility that the action performed serve

only as amortization of tensions, contributing to the sustainability of the mechanisms of power in progress.

According to Reynolds²⁰⁽²⁹⁾,

[...] if we embrace our work as justice-doing we will use our power as community workers and therapists to transform the social contexts of oppression.

Therefore, after a few months in Nauru, the debate was about following the clinical care or using the data collected in the field for public denunciation. The refugees heard believed that a relocation would positively have an impact on their mental health. As already described, the great majority mentioned living in Nauru as the major genesis of their psychic sufferings. However, patients also defined MSF care as an important source of 'rehumanization'. Thus, the ethical-clinical dilemma to be faced was the choice between maintaining a strict clinical performance or leaving Nauru for denunciation purposes, but, for this, leaving the patients without assistance, since any public action, in a given political context, would mean the end of MSF's mission in Nauru.

Jansen et al.¹⁸⁽⁴⁾ conclude that work in immigrant detention centers places

[...] puts doctors in an ethically tenuous position, but, on balance, it is right for doctors to continue to provide medical care to people seeking asylum. In order to do so without being unjustifiably complicit in torture, doctors must practise in an uncompromisingly humanistic way, should publicly speak out about the harms being perpetrated and should be constantly mindful of the potential for corruption.

Final considerations

The lessons for mental health performance are many and inconclusive in the author's

conception. MSF was expelled from Nauru by the local government and was forced to abandon all patients and file a public complaint on October 5th 2018. There are no easy paths to follow in the face of the heinous crime of torture and deprivation of liberty. The extremes of denial and total complicity must be avoided; everyday reflection has become necessary.

In a macropolitical sphere, it is necessary to think about the possible interventions of agencies such as UNHCR in contexts such as Nauru, as well as to reflect on how data collected in humanitarian actions can subsidize pressures for effective changes and resettlements that consider practices of social justice. In a micropolitical sphere, experience

in Nauru makes it clear that, faced with all forms of violence in the interface with mental health, clinical practice with its traditional means – prescription of medication and psychotherapy – tends to be dredged by impossibility. The field's action in the face of violence needs reinvention, social intervention, without submitting to the power instituted, in order to effectively act by fostering mental health, which only happens in freedom.

Collaborators

Schmid PC (0000-0002-0712-4132)* is responsible for field research, data collection, analysis and writing of the manuscript. ■

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