



# INDEFINITE DESPAIR

**The tragic mental health consequences of offshore processing on Nauru**

Médecins Sans Frontières mental health project, Nauru  
December 2018





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# 1. EXECUTIVE SUMMARY



Médecins Sans Frontières/Doctors Without Borders (MSF) provided mental healthcare on the Pacific island of Nauru for 11 months, before being forced to leave by the Nauruan government in October 2018. This report analyses MSF's medical data from Nauru, which demonstrates extreme mental health suffering on the island. Close to one-third of MSF's refugee and asylum seeker patients attempted suicide, while 12 patients were diagnosed with the rare psychiatric condition of 'resignation syndrome'. Nauruan nationals also had high levels of severe mental illness; almost half of MSF's Nauruan patients needed treatment for psychosis.

The data shows that the mental health suffering on Nauru is among the worst MSF has ever seen, including in projects providing care for victims of torture.

MSF calls for an end to Australia's offshore processing policy and for the immediate evacuation of all refugee and asylum seekers from Nauru – men, women and children. Refugees and asylum seekers must have fast access to permanent resettlement, alongside their families, so that they can begin rebuilding their mental health.

## Background information

From November 2017 until October 2018, under an official agreement with the Ministry of Health of Nauru, MSF provided free psychological and psychiatric treatment to Nauruan nationals as well as refugees and asylum seekers sent to the island under the Australian policy of 'offshore processing'.

As a consequence of this policy, asylum seekers who attempted to reach Australia by boat were sent to remote Pacific islands for an indefinite time period to have their asylum requests processed.

Many of these men, women and children have now spent more than five years on Nauru, with catastrophic effects on their mental health.

On 5 October 2018, the Nauruan government informed MSF, without warning, that our services were "no longer required" and must cease within 24 hours. The cessation of services forced MSF to leave behind hundreds of patients in urgent need of continued mental healthcare.

## MSF's mental health activities

In 11 months of activities:

- MSF provided 285 initial mental health assessments and 1,847 follow-up sessions.
- Of the 285 patients, 73% were refugees or asylum seekers and 22% were Nauruan nationals (the rest were foreign workers or had unknown status).
- 1,526 sessions were conducted for refugees or asylum seekers, 591 sessions for Nauruans, and 4 for foreign workers.

MSF also worked on building local capacity in treating mental health disorders, increasing mental health awareness, and decreasing stigmatisation of mental illness.

## MSF's patients

- Aged from under 1 to 74 years old with an average age of 32.
- 19% of patients were under 18.
- 157 were female and 128 were male.
- Of the refugee and asylum seeker patients, 193 (93%) were recognised refugees while 15 (7%) were asylum seekers.
- Most of the refugee and asylum seeker patients were Iranians (76%), followed by Somalis (5%) and Myanmar/ Rohingya (3%).

## Assessing the scale of the mental health crisis

The severity of mental illness among MSF patients was rated using the Global Assessment of Functioning (GAF) scale, which measures the extent to which a patient's symptoms affect his/her everyday life, ranging from 1 for lowest functioning to 100 for highest functioning. Scores above 70 are considered healthy.

MSF's patients had very low scores, in both the Nauruan and the refugee and asylum seeker patient groups.

For the Nauruan patients, the median GAF score at initial assessment was 35, reflecting the high rates of untreated psychosis among this group. For the refugees and asylum seekers it was 40. Other MSF projects that treat severe mental health conditions report medians around 60.

The mental health GAF scores of MSF's refugee and asylum seekers significantly declined in May and June 2018, coinciding with a surge of negative responses to the US resettlement programme, and demonstrating the strong impact of policy decisions on patients' mental health. No such decrease was observed in Nauruan patients during the same time period.

**"Patients spoke about the injustice of their situation. Most people have been recognised as refugees, yet while they have been told there are processes to resettlement, the criteria are unclear. People try to learn the 'rules' of the system, but the rules keep changing. They realise it is impossible to help themselves."**

**DR BETH O'CONNOR, MSF PSYCHIATRIST**

## Refugee and asylum seeker patients

Among the 208 refugees and asylum seekers MSF treated in Nauru, 124 patients (60%) had suicidal thoughts and 63 patients (30%) attempted suicide. Children as young as 9 were found to have suicidal thoughts, committed acts of self-harm or attempted suicide.

Almost two-thirds (62%) of MSF's 208 refugee and asylum seeker patients were diagnosed with moderate or severe depression. The second highest morbidity was anxiety disorder (25%), followed by post-traumatic stress disorder (18%).

A total of 12 adult and child patients (6%) were diagnosed with resignation syndrome, a rare psychiatric condition where patients enter a comatose state and require medical care to keep them alive.

## From war and violence...

MSF's asylum seeker and refugee patients on Nauru were an extremely vulnerable group; 75% reported experiencing traumatic events in their country of origin and/or during their migration journey, including combat situations and detention. Refugees and asylum seekers who had been detained on Christmas Island during their journey were more likely to be suicidal than those who had not been detained there.

Despite their experiences en route, it was the indefinite nature of the Australian government policy that was among the main stressors in their lives.

A total of 65% of refugee and asylum seeker patients felt that they had no control over the events in their lives. These patients were significantly more likely to be suicidal or diagnosed with major psychiatric conditions.

## ...to violence and abuses in Nauru

A total of 23% of refugee and asylum seeker patients reported experiencing violence on Nauru, and MSF's data shows that these patients were significantly more likely to require psychiatric hospitalisation, although this was not always possible because there were insufficient beds.

Disturbingly, 23 (11%) refugee and asylum seeker patients reported experiencing psychological and/or physical violence perpetrated by local authorities including the immigration authorities and Australian Border Force.

MSF's analysis found that more than one-third of asylum seeker and refugee patients were separated from close family members. Families who were split because some members had been medically evacuated – a tactic used by the Australian government to coerce medically evacuated refugees to return to Nauru – were 40% more likely to be suicidal.

### Nauruan patients

MSF's Nauruan patients overall had extremely poor mental health. Close to half (47%) of the 64 Nauruan patients seen by MSF had psychosis. Other morbidities included moderate or severe depression (16%) and disorders due to substance abuse (9%).

At initial assessment, 20 (31%) Nauruan patients were identified as requiring psychiatric hospitalisation (which was unavailable for them), and 61 (95%) were recommended for follow-up treatment, highlighting the severity of their mental illness.

A total of 17 (27%) of MSF's Nauruan patients appeared to have been neglected in term of medical care, mainly due to a lack of available mental healthcare prior to MSF's arrival.

Almost one-third of Nauruan patients reported having experienced traumatic events, particularly domestic violence and sexual violence.

### Access to mental healthcare in Nauru

MSF found that the Nauruan health system is ill-equipped to manage the current mental health crisis on the island. The system is under-resourced, with no inpatient facilities at the Republic of Nauru hospital and insufficient mental health staffing.

MSF's health promotion assessment found that mental illness is stigmatised and poorly understood, leading to poor care for all patients—Nauruans as well as refugees.

Healthcare services contracted by the Australian government also had serious limitations, with insufficient psychiatric inpatient beds and frequent staff turnover. Many refugees and asylum seekers also perceived some of these organisations as complicit in the harsh administration of the offshore processing

policy, which impacted their ability to develop trusting therapeutic relationships.

### Medical evacuations

An official process for medical evacuations (overseas medical referral or OMR) was in place during the time that MSF worked on Nauru. This process was available for Nauruans as well as refugees and asylum seekers who could not find adequate medical care on Nauru. However, this official process did not appear to function effectively, with many cases reportedly remaining on the island despite recommendations for referrals. MSF had no success using the official OMR process, with the only patient referred for this process – a Nauruan patient – failing to be transferred, despite receiving approval.

During the 11 months MSF was on the island, 55 of MSF's refugee and asylum seeker patients were medically evacuated from Nauru, the majority for psychiatric reasons. However, these patients were mostly evacuated by the Australian government following the use or threat of legal action by patients.

### Interruption of care

When MSF was forced to leave Nauru, 208 mental health patients were still under our care. The shock expulsion, with less than 24 hours' notice, meant there was no opportunity to hand over vulnerable patients to other mental health providers, thus interrupting patients' continuity of care. There is now no independent medical provider on Nauru. MSF is deeply concerned for all patients – Nauruans, refugees and asylum seekers – that we left behind.

“The issue of ‘indefiniteness’ – that there is no timeframe for the detention process – has a strong impact on my patients’ mental health. They tell me that even prisoners have a sentence – they know when they will be released, they can plan their lives. My patients don’t have that. So they fear for the future, they are completely hopeless.”

DR PATRICIA SCHMID, MSF PSYCHIATRIST

“The main thing that has caused us to suffer, too much, is about the future. We were recognised as refugees in 2014 but we still don’t know about our future. We applied to be settled in the US, and we recently got the negative results. That decision affected us so, so much. I still don’t know how long it will take to get out of here. This is really hard.”

KAZEM\*, IRANIAN REFUGEE WHO HAS BEEN HELD ON NAURU FOR MORE THAN FIVE YEARS

### Conclusions

MSF's data shows that Nauru is in the grip of a mental health crisis. The mental health suffering on Nauru is among the most severe MSF has ever seen, including in projects providing care for victims of torture.

MSF's data also demonstrates that this alarming level of mental health distress is related to Australia's offshore processing policy. Refugees and asylum seekers have been held on Nauru in limbo for more than five years. The lack of a clear timeframe has led to widespread hopelessness among refugees and asylum seekers. The way in which Australia administers its resettlement policies is widely perceived as opaque and unjust, adding to people's sense they have no control over their lives; a perception that was associated with major psychiatric diagnoses. Family separation due to medical evacuation was also found to be extremely psychologically damaging.

These outcomes are tragically predictable; the harmful mental health impacts of indefinite detention and family separation are well documented in existing mental health research.

Strikingly, most of MSF's Nauruan patients (55%), although extremely unwell, recorded improvements in their mental health GAF scores under MSF's care. By contrast, only 11% of refugee and asylum seeker patients improved, despite receiving the same quality of care.

This underlies MSF's belief that while mental healthcare can help temporarily relieve some symptoms, there is unfortunately no therapeutic solution for asylum seekers and refugees who remain held indefinitely on Nauru. Therefore, MSF believes that the safest way to prevent further harm is to allow all refugees and asylum seekers to leave Nauru, regardless of their current mental health status.

MSF calls for an end to Australia's offshore processing policy and for the immediate evacuation of all refugee and asylum seekers from Nauru – men, women and children. Refugees and asylum seekers must have fast access to permanent resettlement, alongside their families, so that they can begin rebuilding their lives and their mental health.

## 2. INTRODUCTION



### 2.1 Purpose

This report is the first and only independent assessment of the mental health situation of people living on Nauru. The findings demonstrate the negative impact of offshore processing on the mental health of refugees and asylum seekers. It also highlights the inadequacy of mental health services available on Nauru to locals, refugees and asylum seekers.

The information summarised in this report was collected by staff at MSF's mental health project on Nauru, which ran from 1 November 2017 until 5 October 2018.

The data and analysis presented here does not pretend to be fully comprehensive, as it is gathered solely from MSF's patients and their families. However, it adds to existing evidence of the situation on Nauru, and to the impact of the policy and practice of offshore processing of refugees and asylum seekers by the Australian and Nauruan governments.

The report describes:

- The socio-demographic and mental health characteristics of refugees and asylum seekers and Nauruan nationals accessing MSF mental health services.
- The incidence of exposure to violent or traumatic events reported by refugees and asylum seekers accessing MSF mental health services, before and during their migration

journey as well as on Nauru, and the impact of this on their mental health.

- The difficulties experienced on Nauru by refugees and asylum seekers accessing MSF mental health services, and the impact of these on their mental health.

This analysis does not represent the full set of MSF activities on the island, which also included health promotion and capacity building for Ministry of Health staff and other officials of the Government of Nauru.

While the data illustrates the broad mental health findings of MSF on Nauru, it obviously does not provide a full picture of people's needs or the complexity of their experiences.

### 2.2 Context

The Republic of Nauru – the world's smallest republic – is a small island country located northeast of Australia with a population of 11,301<sup>1</sup> and an area of just 21 km<sup>2</sup>. The majority of its residents are indigenous Nauruan nationals with smaller groups of Micronesians from Kiribati, Australians, New Zealanders, Chinese and Tuvaluans.<sup>2</sup>

This tiny nation has not had an easy history. Exploitation by foreign powers, as well as by Australia, has left the island environmentally devastated by phosphate mining, culturally dominated by the influence of Western missionaries, and financially

### "Stop the boats": Australia's border protection and refugee policy

The Pacific Solution refers to a series of Australian government policies which enable the transporting and offshore processing of asylum seekers kept in detention and processing centres on various islands in the Pacific Ocean. This policy prevents asylum seekers from arriving in Australia by boat and claiming asylum in Australian territory. The policy was introduced in September 2001 by the government of Australia in response to the Tampa Affair: a maritime incident in which then Prime Minister of Australia John Howard refused permission for Norwegian ship MV Tampa, carrying 433 rescued refugees predominantly from Afghanistan, to disembark in Australia.

The Pacific Solution consisted of the following strategies: the excision of multiple islands off Australia's northern coast from the Australian migration zone for the purpose of processing irregular arrivals; and the initiation of 'Operation Relex', which permitted the Australian Defence Force to intercept vessels carrying asylum seekers and transport them to Australian-funded processing and detention centres in Nauru and Manus Island, Papua New Guinea (PNG) while their refugee status was determined.

The policy was abolished in 2007, when processing facilities in Nauru and Manus were closed; the last refugees and asylum seekers left Manus in 2004 and Nauru in 2008 for Australia. The policy was revived in 2012 when a new agreement was made to detain and process asylum seekers on Nauru and Manus. The cornerstone of this agreement, known as the 'Pacific Solution Mark II', is that people coming without authorisation to Australia by boat will never be resettled in Australia. Instead, they are sent to offshore locations funded and supported by the Australian government, where they are detained and where their asylum claims are examined by the national authorities. If granted international protection, offshore refugees have three options: to settle in Nauru, where they receive a 20-year visa, or PNG; to await resettlement in a third country; or to repatriate voluntarily, as per the laws of the country of origin, with economical support. In addition, a new naval operation 'Operation Sovereign

Borders' includes the interception of boats carrying refugees and migrants in high seas and towing them back to Indonesian waters.

#### Detention

Until October 2015, refugees and asylum seekers on Nauru were detained in two of three 'regional processing centres' (RPCs). These were sites of detention, surrounded by fencing and patrolled by security guards, with a mixture of accommodation units and tents to house the detainees, and communal services such as toilets, showers and meals. Conditions at these sites were notoriously bad: the UNHCR reported that Nauru did not "provide safe and humane conditions for treatment in detention"<sup>3</sup>. There were many instances of unrest, including serious riots in 2013, as well as thousands of incidents of serious and minor abuses, as detailed in the leaked 'Nauru files'<sup>4</sup> and examined in the Moss Review initiated by the Australian government in October 2014.

The RPCs' gates were partially opened by the Nauruan government in February 2015, allowing refugees and asylum seekers to move around the island. In October 2015, pre-empting an Australian High Court challenge against offshore detention, the RPCs' gates were fully opened and many more refugees were allowed to settle in community housing elsewhere on the island.

#### Bilateral resettlement arrangements

In September 2014, Australia concluded an agreement with Cambodia to allow for the resettlement of refugees from Nauru in Cambodia. In September 2016, the US agreed to consider the resettlement of up to 1,250 refugees from Nauru and Manus. As of 22 October 2018, 276 refugees from Nauru had left for the US and 148 had had their applications turned down.<sup>5</sup>

#### Definitions

**Refugee:** In Nauru, a person is legally recognised as a refugee once s/he has completed the Refugee Status Determination (RSD) process, which confirms that s/he has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership of a particular social group and, as a refugee, the person requires protection.

**Asylum seeker:** In Nauru, this refers to a person who has yet to complete the RSD process.

traumatised by a series of boom-and-bust initiatives, the latest being its financial dependence on the Australian government for managing and hosting refugees and asylum seekers.

These economic pressures have limited Nauru's capacity to develop a well-functioning health service. As in other Pacific countries, the major health conditions affecting adults are non-communicable diseases such as diabetes, obesity, hypertension and rheumatic heart disease. These, along with their long-term complications, are the primary cause of mortality among the adult population.

Unsurprisingly, initial exploratory visits to Nauru by MSF found gaps in the healthcare available, particularly in the area of mental health. At the Republic of Nauru hospital, mental health services were established as recently as 2006, and consist of one doctor and few nurses with some training in mental health, bolstered occasionally by a visiting mental health specialist. There are still no acute inpatient treatment facilities, nor is there a permanent psychiatrist amongst the Ministry of Health staff. Patients who pose a risk to themselves or others are detained by police.

At the time of MSF's initial assessment, there were at least 134 registered Nauruan mental health patients, who had limited access to these services, while other cases went untreated in the community.

When MSF started its mental health activities on the island in November 2017, 1,099<sup>6</sup> refugees and asylum seekers, including 115 children – 30 of whom were born in Nauru – had been on the island for around four years.

Refugees and asylum seekers on Nauru originate mainly from Iran, Somalia, Afghanistan, Pakistan, Sri Lanka, Myanmar, Iraq and Lebanon. Some refugees live in the community; others are housed in the 'regional processing centres' (RPCs).<sup>7</sup>

#### Mental health and refugees

Nauru is not strictly a detention setting, since the RPCs stopped being closed facilities in October 2015, but many refugees and asylum seekers described the island to MSF as an "open-air prison". Unlike the local population, who are free to come and go, refugees and asylum seekers are trapped indefinitely on Nauru. They are denied the freedom to reunite with family members elsewhere, or to build lives beyond the very limited opportunities available on the island.

This lack of liberty has been imposed by an Australian policy that arbitrarily targets people who arrive by

boat rather than by other means. Even amongst these arrivals, people were dealt with differently, with some resettled in Australia and others taken to Nauru or Manus, in a process with little to no transparency.

MSF believes that the offshore processing policy is the most significant contributory factor in the mental health problems experienced by MSF patients from the refugee and asylum seeker community. This link was reflected both in clinical interviews with patients, and in the association between factors related to their detention (such as family separation and a lack of control over the future) and adverse mental health outcomes.

**“Patients spoke about the injustice of their situation. Most people have been recognised as refugees, yet while they have been told there are processes to resettlement, the criteria are unclear. People try to learn the ‘rules’ of the system, but the rules keep changing. They realise it is impossible to help themselves.”**

**DR BETH O'CONNOR, MSF PSYCHIATRIST**

The processing and confinement of refugees and asylum seekers on Nauru is often misrepresented by politicians in Australia, who overemphasise the comfortable living conditions and the availability of services, even to the extent of describing it as "a very pleasant island" life.<sup>8</sup>

During the period that MSF worked on Nauru, three events had a pronounced negative impact on the mental health of the refugee and asylum seeker community. These were: a wave of refusal of applications to the US resettlement programme in May 2018; the death of a well-respected young asylum seeker in June 2018; and the fifth anniversary of the implementation of the offshore policy in September 2018.

As the timeline right shows, the period in which Nauru has been used as a detention centre has been characterised by a series of events which have touched all the refugees and asylum seekers held there. Many of these experiences were psychologically damaging. Compounding this, many detainees have suffered traumatic incidents during their time on the island, including abuse, harassment and violence. It is the cumulative effect of these traumas, in the context of indefinite and arbitrary isolation, that has been so injurious to the mental health of this population.

#### Timeline of key Nauru moments

- JUL 2012** ■ Memorandum of understanding is signed by governments of Australia and Nauru
- SEP 2012** ■ First refugees and asylum seekers arrive on Nauru
- SEP 2013** ■ Kevin Rudd announces the 'never be settled in Australia' policy<sup>9</sup>
- OCT 2013** ■ Rioting breaks out at Nauru regional processing centres
- OCT 2014** ■ Save the Children staff expelled from Nauru
- OCT 2015** ■ Gates of the regional processing centres are opened, allowing refugees and asylum seekers to move freely on the island
- APR 2016** ■ 23-year-old refugee sets himself on fire during UNHCR visit and 26-year-old refugee dies of a suspected overdose
- NOV 2016** ■ US resettlement programme is announced
- SEP 2017** ■ MSF team arrives on Nauru
- NOV 2017** ■ 29-year-old refugee dies in a motorbike accident
- MAY 2018** ■ Large numbers of people have their applications to resettle in the US rejected
- JUN 2018** ■ Death of respected young asylum seeker on Nauru
- JUL 2018** ■ Five-year anniversary of the 'never be settled in Australia' policy
- OCT 2018** ■ MSF team is forced out of Nauru

## 2.3 MSF presence in Nauru

Following the signing of a memorandum of understanding (MoU) between MSF and the Ministry of Health of Nauru, MSF began working in Nauru in September 2017. In November 2017, MSF opened a 'one door for all' psychological and mental health programme, which included psychiatric care. The service was available to locals as well as asylum seekers and refugees.

MSF also worked on building up local capacity to treat mental health disorders, on increasing awareness of mental health issues, and on decreasing stigma within

the local community towards those with mental illness.

On 5 October 2018, after 11 months of providing mental health care on Nauru, the Nauruan government informed MSF that its services for Nauruan nationals, refugees and asylum seekers were "no longer required" and instructed that its activities cease within 24 hours.

At this point, MSF had provided treatment to 285 patients over the course of 2,132 consultations. The cessation of services forced MSF to leave behind hundreds of Nauruan, refugee and asylum seeker patients in need of continued mental health care.



**24 HOURS  
NOTICE**  
to cease our activities



**11 MONTHS**  
providing mental  
healthcare on Nauru



**2,132**  
mental health  
consultations  
made

### From the Memorandum of Understanding (MoU) between the Ministry of Health of the Republic of Nauru and Médecins Sans Frontières

SIGNED JUNE 2017, RE-SIGNED MAY 2018

#### Object of the MoU:

The goal of this Memorandum of Understanding is to enable MSF to provide assistance to members of the various communities living in the Republic of Nauru by providing mental health services ("the Project").

#### Beneficiaries of the Project:

People suffering from various mental health issues, from moderate to severe, members of the various communities living in the Republic of Nauru, including Nauruan residents, expatriates, asylum seekers and refugees with no discrimination (referred to as "local residents and migrants" in this MoU).

#### Description of the Project:

Overall objective of the Project: To promote well-being through a 'one equal door service for psychosocial and mental health' to all local residents and migrant population in the Republic of Nauru.

#### Specific objectives of the Project:

1. The strengthening of psychological support for psychiatric cases.
2. The enhancement of coping mechanisms for the targeted population experiencing mental health problems and disorders in order to prevent/reduce psychological suffering.
3. The development of further capacity within the Ministry of Health staff for the identification and treatment of mental disorders.

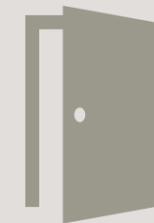
"In a small community that has spent five years together, events have a wide impact. In June, there was the suspected suicide of a young asylum seeker. He was a talented soccer player, well known and respected, so his death was felt deeply by many. This event contributed to further despair, and the community struggled to find the resources to support each other. There was a similar effect in family units: when one person was sick, we would see the whole family collapse."

DR BETH O'CONNOR, MSF PSYCHIATRIST

#### Description of MSF's mental health activities on Nauru

Under the 'one door for all' approach, the MSF team offered individual, couple or family consultations to all those in need, including Nauruans, refugees, asylum seekers and international staff living on Nauru. Our medical team was composed of a mental health manager, two psychiatrists, a psychologist, two cultural mediators (interpreters), and one health promoter. Our staff were based in a clinic within Nauru

public health centre, but also conducted home visits to patients and their families, and collaborated with the nurses at Republic of Nauru hospital to support psychiatric services for Nauruan nationals. Prior to our team's forced departure from Nauru, we had started running psychoeducation groups specifically for Nauruan patients and were planning to run additional psychosocial activities for all of our patients, based on our assessment of the mental health needs on Nauru.

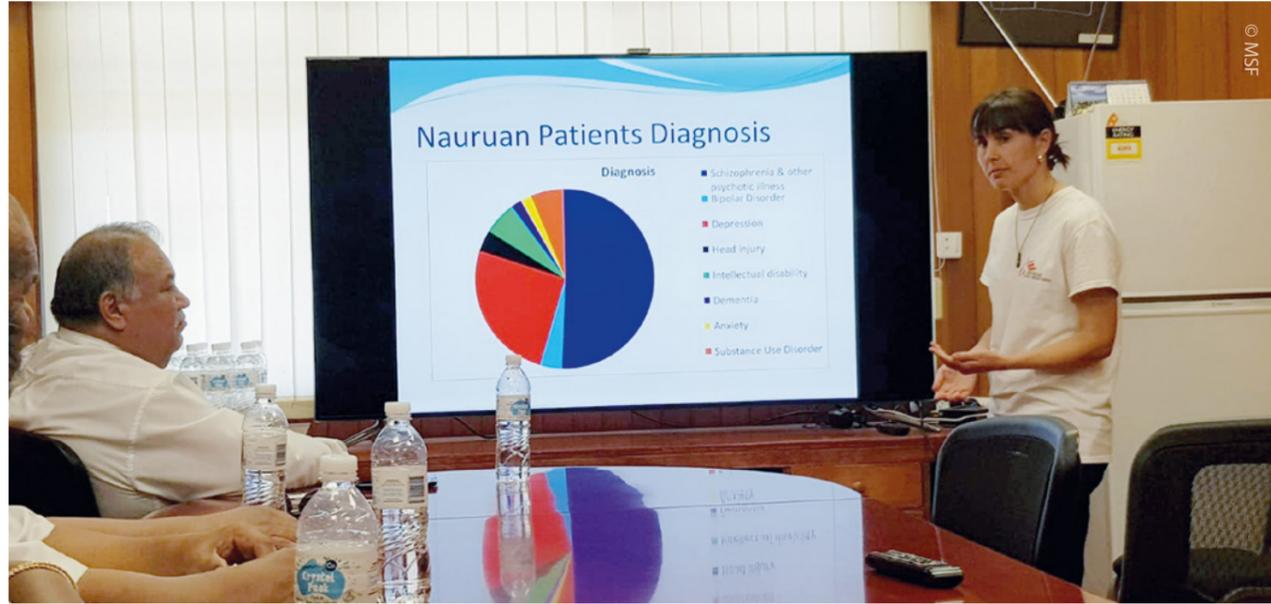


**ONE  
DOOR  
FOR ALL**

From the outset of the project, MSF had support from Nauru's Minister for Health and Medical Services and from medical staff directly and indirectly involved in providing mental healthcare. However, officials from the Department of Multicultural Affairs (MCA), who are responsible for managing the refugee and asylum seeker population, were not willing partners. Despite repeated efforts by MSF, senior MCA officials refused to meet with MSF or acknowledge our MoU with the Ministry of Health.

As the project continued, MSF teams faced increased hostility and obstructions by government officials. Our staff were forcibly made to leave the hospital in the middle of providing patient care; other organisations were ordered not to refer refugees and asylum seekers in need of mental health care to MSF's clinic; MSF staff were not always allowed to enter refugee and asylum seeker housing and were never given access to the RPCs; there were delays in issuing visas for MSF staff. These actions compromised the quality of the care MSF could provide to the refugees and asylum seekers as well as to Nauruans.

## 3. METHODOLOGY



### 3.1 Data sources

#### Mental health database

Since the inception of MSF's mental health programme on Nauru, routine patient data was collected and stored in a clinical mental health database. This database was modelled on the standard MSF mental health database, as used in all MSF projects worldwide. It was adapted to capture specific variables of the context. This data was collected from 1 November 2017 to 5 October 2018. This database contains standardised and pseudonymised information on a patient's demographics, family situation, travel history, traumatic events before and during the migration journey, difficulties faced in Nauru, mental health diagnosis, potential need for follow-up consultation or psychiatric hospitalisation, mental health severity as characterised by the Global Assessment of Functioning (GAF) score, and follow-up history. Additional data on medical evacuations and self-harm, suicidal ideation and suicide attempts was provided as an update for this report. This is the main source of data for this report.

The data was collected as per MSF data collection policy in full respect of medical ethics and medical confidentiality. The data was collected primarily for the clinical management of our patients; subsequently the data was used in a secondary analysis.

The analysts received a confidential, password-protected, pseudonymised version of the database, without access to the key linking patient identities with patient codes.

#### Debriefing notes and project log

Summary notes drafted by MSF staff following debriefing sessions, which detail staff observations on the situation in Nauru, also form part of this analysis. The debriefings were semi-structured discussions focused on their experience of working in Nauru, observations of trends, stakeholder relationships and notable incidents. In total, 29 debriefings of 15 staff members were completed over the course of the programme. The project log was compiled from April 2018 to capture significant events pertinent to the context of life on Nauru for all patients and staff.

### 3.2 Data analysis

A descriptive analysis of the information gathered from the database described above was conducted to present summary statistics and narrative descriptions on the situation of all patients who accessed MSF's mental health services from 1 November 2017 to 5 October 2018. A comparative analysis of patients' level of functioning (i.e. the extent to which their symptoms affected their daily lives) and mental health outcomes, and their relationship with traumatic events and post-migration difficulties, was also conducted using EpiData Analysis Software v2.2. Additional data from the staff debriefings and project log – where relevant to the findings of the analyses of the mental health database – were summarised and included to supplement the information presented in this report.

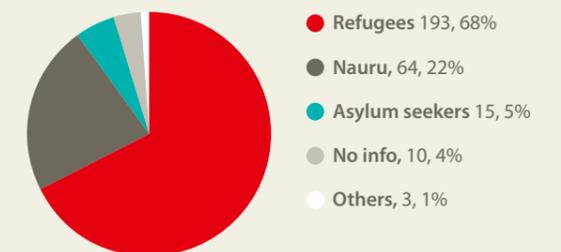
## 4. FINDINGS



From the start of MSF's mental health and psychosocial project in Nauru on 1 November 2017, to its end on 5 October 2018, MSF provided psychological and/or psychiatric interventions to 285 individuals.

### 4.1 Demographics

Chart 1: Country of origin and legal status of patients

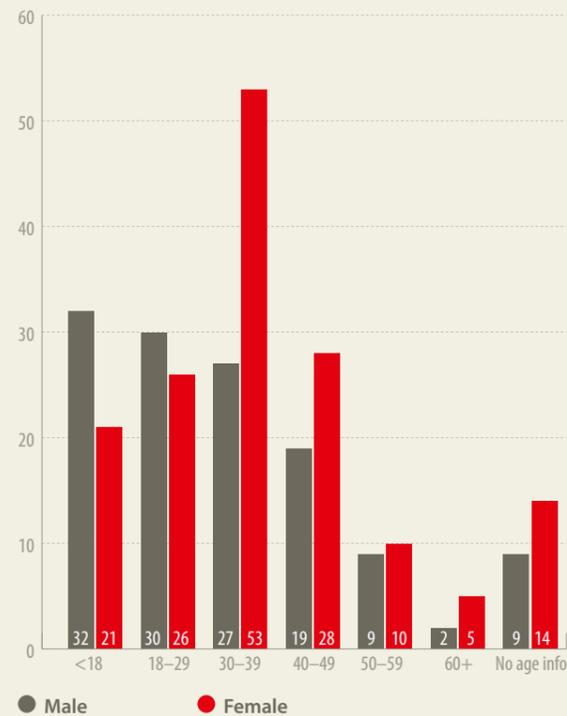


**Table 1: Countries of origin of refugee and asylum seeker patients**

Country	No. of patients	% of patients
Iran	158	76%
Somalia	11	5%
Myanmar	7	3%
Afghanistan	6	3%
Sri Lanka	6	3%
Lebanon	5	2%
Iraq	3	1%
Bangladesh	3	1%
India	2	1%
Others	6	3%
Unknown	1	0.5%
<b>Total</b>	<b>208</b>	

\* Denominator for % = total number of refugees and asylum seekers who received services

**Chart 2: Gender of patients by age group**



**Table 2: Age characteristics of total patient group**

Characteristic	No. (Years)
Age range	0–74
Mean age	31.8
Median age	32
Male to female ratio	0.8

### Age and gender of patients

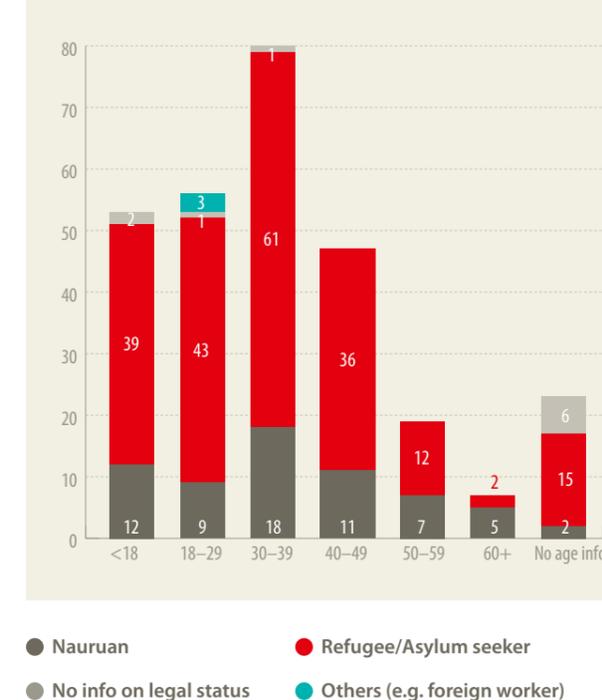
Of the total patient cohort, 157 (55%) were females and 128 (45%) were males. The age range of the patients seen at point of assessment was from under one year old to 74 years, with a median age of 32 [Table 2]. Children below the age of 18 represent 19% of the patient group. The median age of males was 29 and of females was 34. The male-to-female gender ratio for the total patient group was 0.8. Comparing the age groups, more male children and young adults were seen by MSF, with a male-to-female gender ratio of 1.5 for those under the age of 18, and 1.2 for those aged between 18 and 29. This ratio was equivalent to less than 1 in older age groups: 30-39 (0.5), 40-49 (0.7), 50-59 (0.9), 60+ (0.40) [Chart 2]. There were almost twice as many females than males within the 30 to 39 age range who sought mental health services from MSF.

**Table 3: Age and gender ratio for Nauruan and refugee and asylum seeker patients**

Characteristic	Nauruan nationals	Refugees and asylum seekers
Age range	4 years–74 years	Less than 1 year–68 years
Median age	35 years	32 years
Male-to-female ratio	0.5	0.9

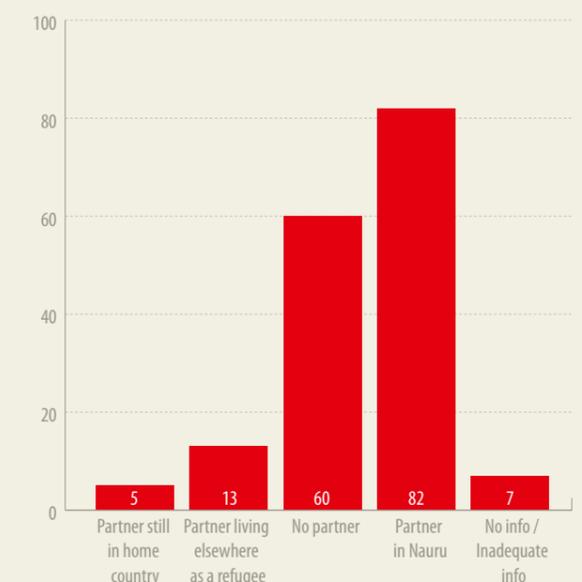
Among the refugee and asylum seeker patients, the largest age group was from 30 to 39 (29%), and 19% were children aged under 18 [Chart 3]. Among the 39 refugee and asylum seeker children, 3 were younger than 6 years old, 17 aged from 7 to 12, and 19 aged from 13 to 17. The male-to-female ratio for refugee and asylum seeker patients was 0.9. Against a male-to-female ratio of 0.36 in the refugee and asylum seeker population in November 2017, this indicates that refugee and asylum seeker females were more likely than males to seek mental health services in Nauru. Similarly, there were more female than male Nauruan patients who sought mental health services from MSF.

**Chart 3: Patients by age group**

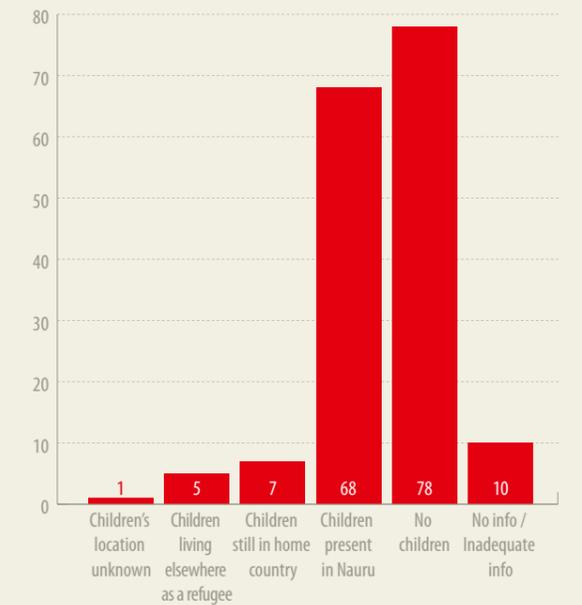


### 4.2 Family situation of refugee and asylum seeker patients

**Chart 4: Situation of partner for adult refugee and asylum seeker patients**



**Chart 5: Situation of children for adult refugee and asylum seeker patients**



Of the 208 refugees and asylum seekers seen by MSF, **76 (37%) were separated from a partner, child or other close family member.** Of this number, 8 (4%) were documented to be separated from both partner and children. 18 (11%) refugees and asylum seekers were separated from their partners, who were either still in their home country or living elsewhere as

refugees [Chart 4], and 13 (8%) were separated from their children, who were either in their home country or living elsewhere, or their location was unknown [Chart 5]. 68 (33%) had other family members separated from them. The majority of the refugee and asylum seeker children seen by MSF reported having at least one family member in Nauru.

### Family Separation

Until late 2016, refugee and asylum seeker patients requiring medical evacuation to Australia were routinely accompanied by their immediate family members. After this date, the Australian government began to transfer patients alone or with a single family member, thereby separating families. A *Guardian* newspaper report in July 2018 claimed that departmental sources confirmed this was an “unofficial policy” to “use family separation as a coercive measure to encourage refugees in split families to return to Nauru”.<sup>11</sup> The effect of this practice, as witnessed by MSF staff, is devastating to the mental health of the families affected.

Previous studies describe a clear link between family separation and mental health problems, and provide evidence that family separation is psychologically detrimental to refugee and asylum seeker adults and children, in particular those who are subject to arbitrary detention.<sup>12–15</sup> Family separation is known to be a key stressor<sup>14</sup> and one of the most common causes of self-harm.<sup>15</sup> Separation compounds post-traumatic stress responses and bereavement, causing further psychological distress.<sup>16</sup> In an MSF health promotion assessment of people’s perceptions of mental health and the health-seeking behaviour of the population on Nauru, refugees and asylum seekers perceived the family as the only source of support for a person with mental illness. Separation from family members left people feeling extremely vulnerable and isolated, worsening their state of mental health.<sup>17</sup>

Our patients who were separated from a family member due to a medical transfer to Australia were

**40% MORE LIKELY TO HAVE SUICIDAL ideation and/or attempt suicide.**



MSF’s analysis of its mental health data confirms this clear link between the Australian government’s separation policy and mental health problems. A significant proportion of our patients were separated from family members, contributing to the deterioration of their mental health. Family separation was particularly distressing for children who were separated from one parent.

The analysis in *Chart 20* also indicates a significant association between separation from family members while in Nauru due to medical evacuations abroad and suicidal ideation and/or attempted suicide (RR 1.4, 95%CI 1.1-1.7, p=0.02). This indicates that our patients who were separated from a family member due to a medical transfer to Australia were 40% more likely to have suicidal ideation and/or attempt suicide.

Despite the fact that the impact of family separation has been well documented<sup>18</sup>, the government of Australia has continued to implement this harmful practice by excluding family members not physically present on Nauru from resettlement to the US.

“One of the most distressing outcomes of this policy of indefinite trapping of refugees on Nauru is that of family separation. Our mental health team has worked with multiple fathers who have been separated from their wives and children for months or for years. Fathers told us: ‘I wasn’t there to support my wife during her pregnancy or childbirth; I wasn’t there when my baby took his first breath.’”

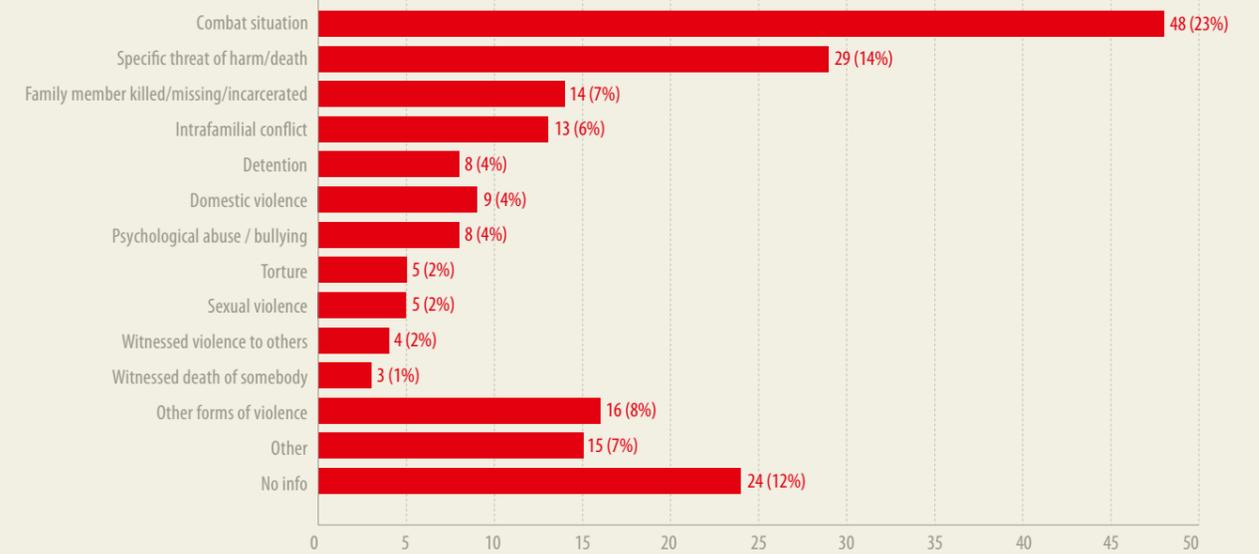
**DR CHRISTINE RUFENER, MSF CLINICAL PSYCHOLOGIST**

### 4.3 Exposure to difficulties and traumatic events

The data below was collected over the course of multiple consultations with patients, who did not necessarily disclose everything that had happened to them, meaning there is a likelihood of under-reporting of exposure to traumatic events, in particular those associated with stigma (such as sexual violence).

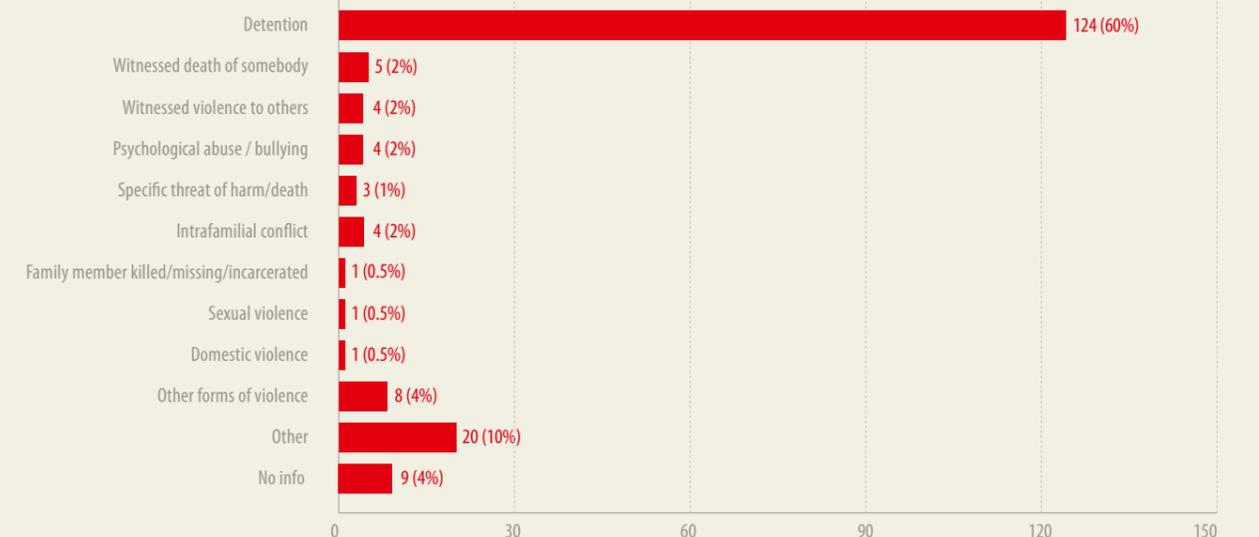
#### 4.3.1 Exposure to traumatic events among refugee and asylum seeker patients

Chart 6: Exposure to traumatic events pre-migration among refugees and asylum seeker patients



Patients could report more than one traumatic event

Chart 7: Exposure to traumatic events during migration among refugees and asylum seeker patients



Patients could report more than one traumatic event

As observed from our data, the scale of trauma experienced by our refugee and asylum seeker patients was very high, with 155 (75%) reporting one or more traumatic events in their country of origin and/or during their migration journey. This indicates that the refugee and asylum seeker patients seen by MSF were already extremely vulnerable upon arriving on Nauru. Of the 208 refugees and asylum seeker patients, 110 (53%) reported one or more traumatic events in their country of origin, most commonly due to combat situations (23%), specific threats of harm or death (14%), having experienced family members killed or incarcerated or missing (7%), intrafamilial conflict (6%), domestic violence (4%) and detention (4%).

During the migration journey, detention was the most common cause of trauma, reported as a traumatising event by more than half of the refugee and asylum seeker patients seen by MSF (124 patients, or 60%) [Chart 7]. Overall, 1 person (0.5%)

was detained for 1 to 2 years on Christmas Island, 54 people (26%) for 6 to 11 months, 30 (14%) for 2 to 5 months, 41 (20%) for 1 week to 1 month, and 19 (9%) for less than a week. In locations other than Christmas Island, 2 people (1%) were detained for 2 to 5 months, 4 (2%) were detained for 1 week to 1 month, and 9 (4%) were detained for less than a week. This indicates that the refugee and asylum seeker patients seen by MSF were subject to periods of detention of varying lengths during their migration journey.

These reports of traumatic experiences also held true for children among the refugee and asylum seeker population: of the 39 children seen by MSF, 29 (74%) reported one or more traumatic events in their home country and/or during the migration journey. These events include experiencing a combat situation, intrafamilial conflict, a specific threat of harm or death, a family member killed, missing or incarcerated, detention, witnessing the death of another person and other forms of violence.

In total, 191 refugee and asylum seeker patients (92%) reported facing difficulties in Nauru, which likely exacerbated their feelings of vulnerability and mental health problems. Among the stressors experienced, 134 patients (64%) felt that they could not control the events in their lives and similarly 134 patients (64%) had fears for the future. 73 (35%) cited a lack of daily activities as a stressor and 28 (13%) expressed distress resulting from being separated from a family member due to medical transfer overseas. 47 people – or almost one quarter of the refugee and asylum seeker patients – (23%) reported experiencing physical violence of some form while in Nauru. Of all refugee and asylum seeker patients, 23 (11%) had encountered psychological and/or physical violence perpetrated by local authorities, including the immigration authorities and Australian Border Force (ABF). 26 (13%) said they were victims of violence by Nauruan nationals [Chart 8]. A recurrent theme that emerged from the debriefing documents in relation to these findings was the sense of hopelessness that people felt at having no control over the events in their lives.

“After a while we found out that there is no difference between the tent and the community, because you’re just transferred from a small prison to the big prison that’s surrounded by ocean.”

**KAZEM\*, IRANIAN REFUGEE WHO HAS BEEN HELD ON NAURU FOR MORE THAN FIVE YEARS**



**75%**  
reported one or more traumatic events in their country of origin and/or during their migration journey

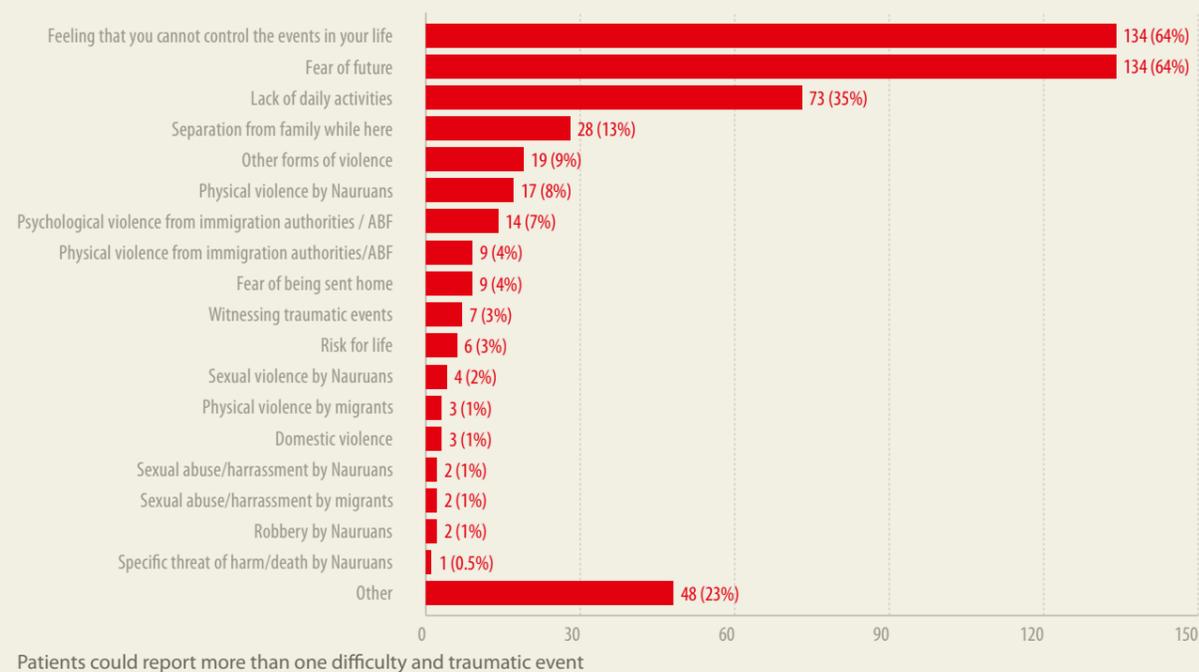


**DETENTION**  
was the most common cause of trauma during the migration journey



**91%**  
of refugee and asylum seeker patients reported facing difficulties in Nauru

**Chart 8: Difficulties and traumatic events experienced by refugee and asylum seeker patients on Nauru**



### Traumatic events

This information represents a sample of traumatic events directly reported to MSF staff by Nauruans, refugees and asylum seekers between April and October 2018. The information is neither comprehensive nor is it necessarily representative, and the events reported occurred both before and during the reporting period.

Overall, MSF recorded 46 incidents of exposure to harm, violence, and/or traumatic events on Nauru. Because these incidents were only recorded in the final six months that MSF worked in Nauru, the number of incidents is less than those reported in Charts 8 and 9.

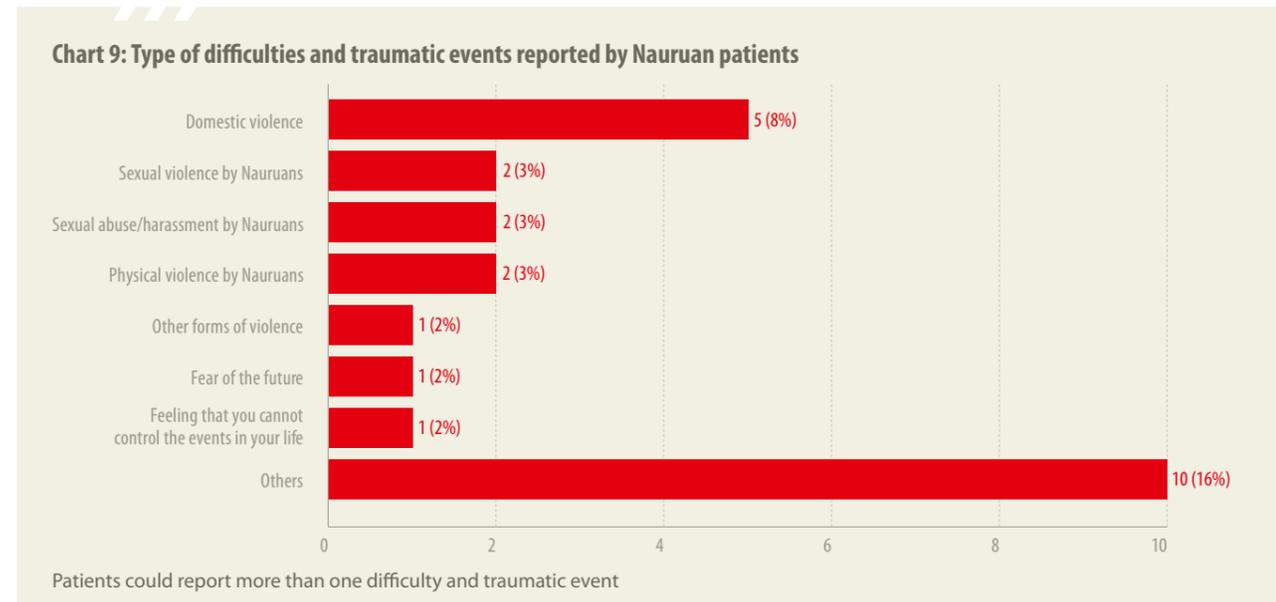
During consultations, MSF received reports from Nauruans, refugees and asylum seekers, both children and adults, of physical and sexual violence. The alleged perpetrators were often reported to be Nauruans but, in some instances, refugees and asylum seekers were the reported offenders. There were also reports of the alleged perpetrators being authority figures, including guards in the RPCs and police officers. With some incidents of physical violence, weapons including metal or wooden objects were used.

Generally, there was a reluctance amongst

Nauruans, refugees and asylum seekers to report these incidents to the police. When they did tell the police about acts of violence, often no effort was reportedly made to find the perpetrators. Our patients even reported instances where victims of violence were threatened by the police if they continued to request that the incident be investigated. Some refugees and asylum seekers reported being scared to leave their homes for fear of becoming targets of violence. Refugees and asylum seekers also reported being robbed, particularly in the RPCs, by RPC staff.

Traumatic incidents of this kind may have a significant impact on people’s mental health in themselves, but when a person has experienced previous psychological trauma, these incidents may have a compounding effect. Further exposure to trauma may exacerbate symptoms of post-traumatic stress disorder (PTSD). MSF saw patients who were unable to take part in therapy to address their psychological trauma due to feeling unsafe in Nauru and to being exposed to repeated triggering of their PTSD symptoms. In order to fully engage in mental health treatment – to reduce the severity of symptoms and to obtain any level of relief – patients need to feel safe and secure in their environment.

### 4.3.2 Exposure to traumatic events among Nauruan patients



Among the 64 Nauruan patients, 19 (30%) reported experiencing difficulties and traumatic events in Nauru. Of these, 5 (8%) reported domestic violence, 2 (3%) reported sexual violence by Nauruans, 2 (3%) reported sexual abuse or harassment by Nauruans and 2 (3%) reported physical violence by Nauruans [Chart 9]. The majority of these acts of violence occurred towards patients with chronic psychotic disorders who are more vulnerable to abuse and neglect. When Nauruan patients were severely mentally unwell, there was no option of hospitalisation to provide further management and protection.

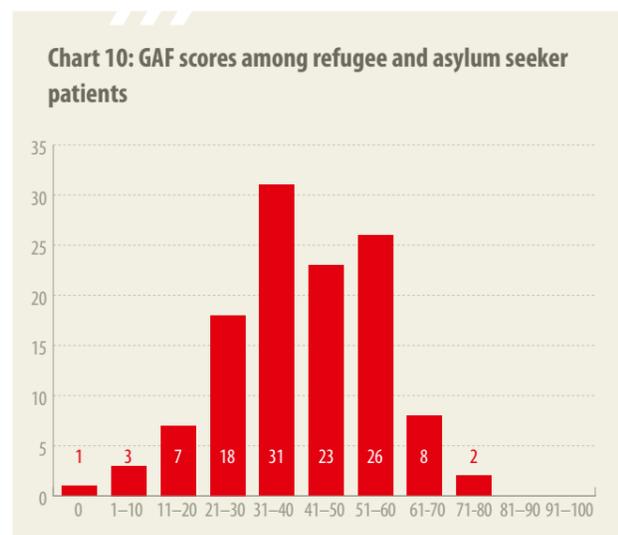
### 4.4 Mental health morbidities

#### 4.4.1. Severity of mental conditions among refugee and asylum seeker patients

The GAF scale – which measures the extent to which a patient’s symptoms affect his or her daily life on a scale of 1 to 100 – was used to rate the severity of mental illness of 119 patients seen by an MSF psychiatrist [refer to Appendix].

On the GAF scale, scores of 91-100 indicate optimal mental health and coping abilities, while scores of 71–90 are categorised as “healthy”. A GAF score of 40 generally represents a major impairment in several areas of their life simultaneously [refer to Appendix].

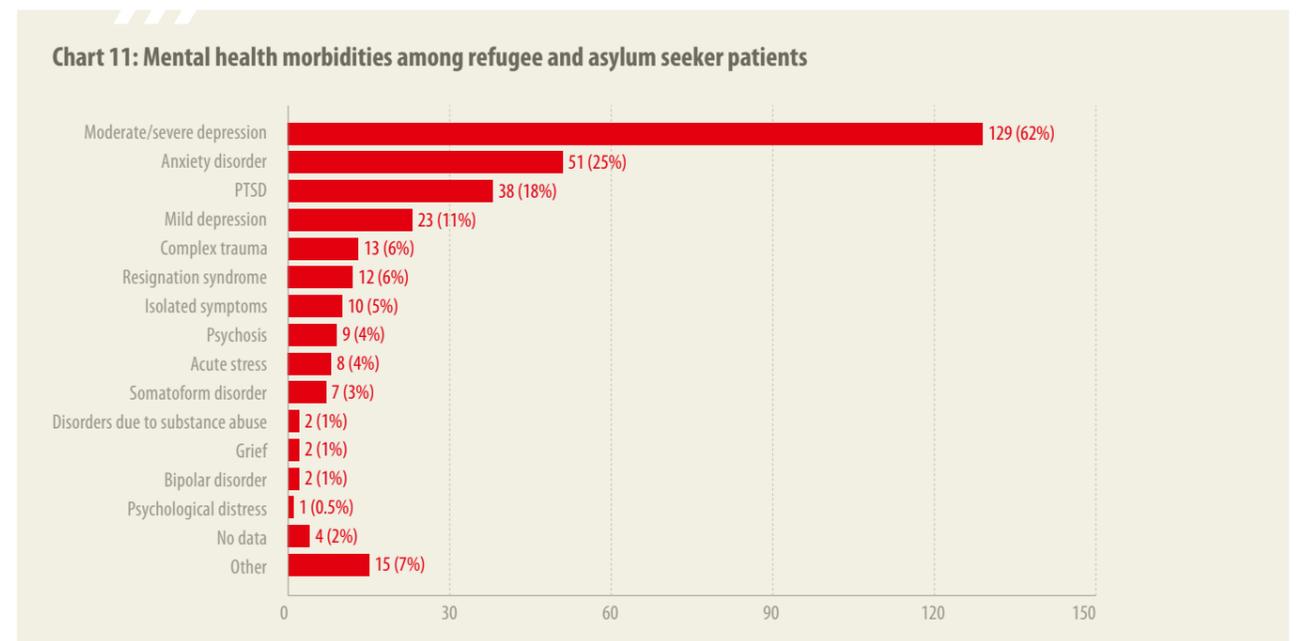
The median GAF score for refugee and asylum seeker patients evaluated at the first clinical assessment was 40. The most common GAF score for refugee and asylum seeker patients was in the category of 31–40, with 31 patients (15%) scoring in this range [Chart 10].



#### 4.4.2 Mental health morbidities among refugee and asylum seeker patients

Morbidity was recorded based on diagnoses given by the MSF psychiatrist or psychologist assessing the patient. Up to six diagnoses were recorded for each patient throughout the period of therapy at point of assessment and during follow-up.

Among the 208 refugee and asylum seeker patients assessed by MSF, 129 (62%) were diagnosed with moderate to severe depression. The second highest morbidity was anxiety disorder (25%), followed by PTSD (18%), mild depression (11%), complex trauma (6%) and resignation syndrome (6%), also known as traumatic withdrawal syndrome<sup>19</sup>. Some patients had isolated symptoms (5%), psychosis (4%), acute stress (4%) or somatoform disorder (3%) [Chart 11].



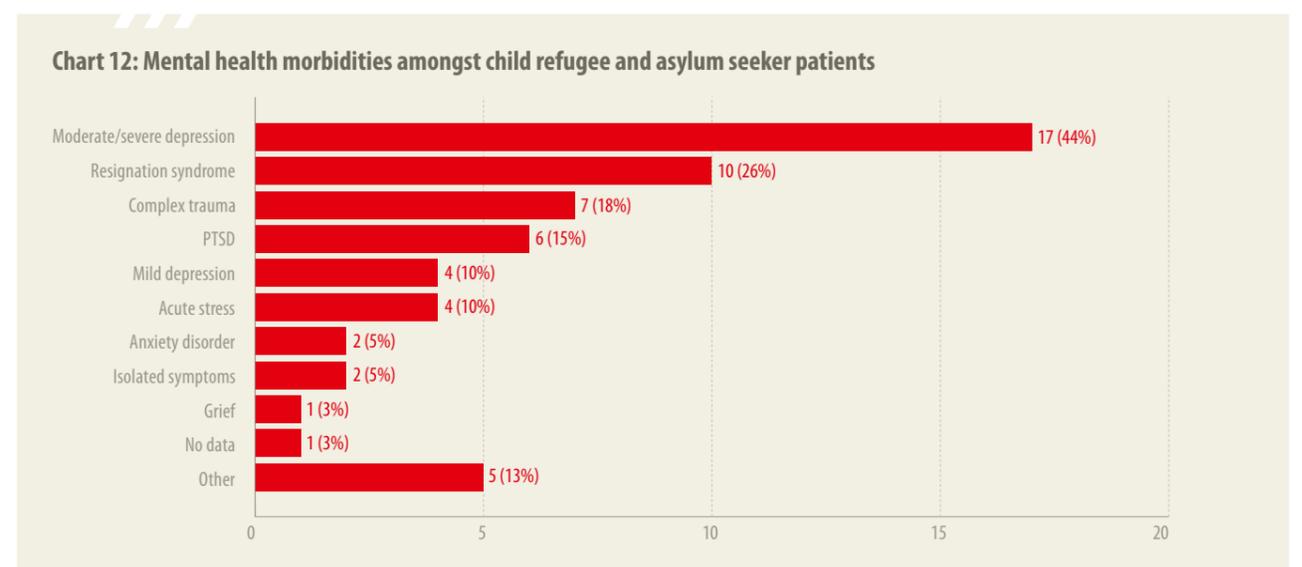
Compared to the Nauruan patients (18, 50%), a larger proportion of refugees and asylum seekers (133, 64%) had multiple co-morbidities.

The high prevalence and severe mental health morbidities among our patients was evident. As observed by MSF staff, the high rate of depression among our patient group was likely due to the traumatising conditions experienced on Nauru. Experiencing physical violence on Nauru was associated with higher rates of complex trauma and PTSD (RR 2.4, 95%CI 1.5-3.9, p=0.0005); experiencing fear for the future was associated with moderate to severe depression (RR 1.4, 95%CI 1.1-1.8, p=0.002); and experiencing a lack of control over the events that affect one’s life was associated with all major diagnoses: complex trauma and PTSD (RR 1.3, 95%CI 1.1-1.6, p=0.03); moderate to

severe depression (RR 1.5, 95%CI 1.1-1.9, p=0.0008); and anxiety disorder (RR 1.4, 95%CI 1.3-1.7, p=0.002).

The main morbidities (moderate to severe depression, anxiety disorder and PTSD) are all serious mental health conditions that require long-term and specialised care, which was extremely limited on Nauru throughout the project period. In general, the mental health situation for asylum seekers was observed to be worse than for refugees, likely reflecting a greater degree of ambiguity about, or control over, their future.

After MSF’s initial assessment, 99 (48%) refugee and asylum seeker patients were prescribed psychotropic medication, 5 of whom were children. A further 20 (10%) were identified as requiring psychiatric hospitalisation, 7 of whom were children. Overall, 191 (92%) were recommended for follow-up interventions.



Of the 39 refugee and asylum seeker children seen by MSF, 17 (44%) were diagnosed with moderate to severe depression. Children among our patients also suffered from other serious mental health conditions including resignation syndrome (26%), complex trauma (18%) and PTSD (15%) [Chart 12]. Based on staff observations, the worsening mental health condition among children had a significant impact on the entire refugee and asylum seeker community.

When one family member became unwell, the rest of the family would use all their resources to provide increased care and support to that family member. When a refugee or asylum seeker family member became unwell on Nauru, MSF staff witnessed a domino effect where the mental health of the other family members would then also deteriorate. After five years of indefinite containment on Nauru, most refugee and asylum seeker families no longer have the necessary resources to be able to support each other.

Information on resignation syndrome was only systematically recorded by MSF in the last months of the project. During their period of care under MSF, 10 child and 2 adult patients had resignation syndrome.

### What is resignation syndrome?



Resignation syndrome is a very severe form of depressive disorder that can lead to a catatonic state. The rare psychiatric condition is mainly seen in children. It was first observed among refugee children in Sweden, where it was named resignation syndrome, although in Australia it is sometimes referred to as traumatic withdrawal syndrome.<sup>19</sup> Professor Louise Newman of the University of Melbourne has described the syndrome thus:

“The condition starts as a progressive social withdrawal and reluctance to engage in usual activities such as school and play. Children may become isolated and appear depressed and irritable. They frequently resist others’ attempts to support or encourage them to engage.

As the condition progresses, children may stop talking and isolate themselves in bed; they may also stop eating and drinking. The most serious stage of the disorder is when children enter a state of profound withdrawal and are unconscious or in a comatose state.

This comatose state appears to be a state of ‘hibernation’ in response to an intolerable reality. They are unresponsive, even to pain. They appear floppy, without normal reflexes, and require total care, including feeding and intravenous fluids, as otherwise they risk kidney failure and death from complications caused by immobility, malnutrition and dehydration. This is a life-threatening condition needing high-level medical care.”

Source: Newman, L.K. 2018, ‘Explainer: what is resignation syndrome and why is it affecting refugee children?’, The Conversation, 22 August, <<http://theconversation.com/explainer-what-is-resignation-syndrome-and-why-is-it-affecting-refugee-children-101670>>

### 4.4.3 Severity and mental health morbidities among Nauruan patients

Chart 13: Mental health morbidities among Nauruan patients

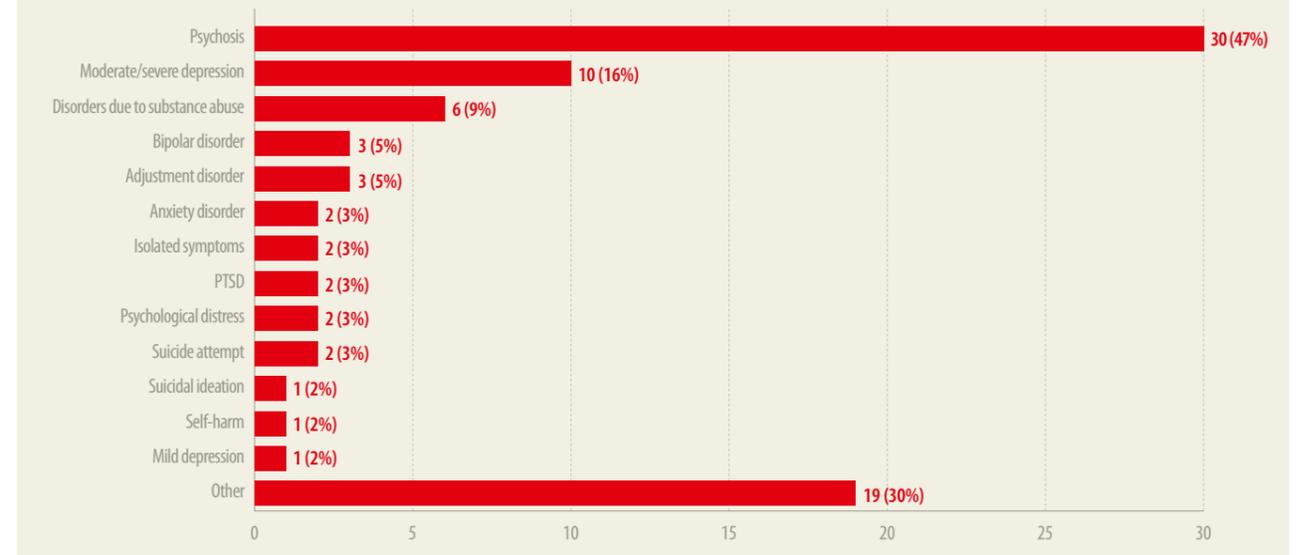
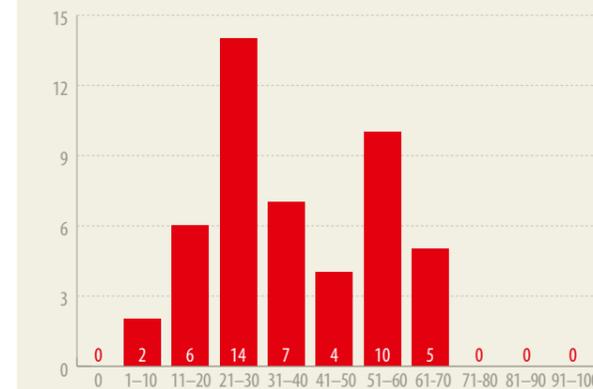


Chart 14: GAF scores among Nauruan patients



Close to half (47%) of the Nauruan nationals seen by MSF had psychosis. The youngest patient with psychosis was 16 years of age and the oldest patient was 74. Of these, 11 had suffered sexual or physical abuse and/or neglect. The second most common morbidity among Nauruan nationals was moderate to severe depression (16%), followed by disorders caused by substance abuse (9%) [Chart 13]. 18 (28%) had co-morbidities of at least two or more mental health diagnoses.

The median GAF score determined at assessment was 35 for Nauruan patients. The most common GAF score range was in the category 21-30 (22%) [Chart 14]. A GAF of 30 generally represents a serious impairment in communication or judgement [refer to Appendix].

A majority of the Nauruan patients (37, or 58%) were referred to MSF working in collaboration with mental health staff at the Republic of Nauru hospital. At initial assessment, 29 (45%) were on psychotropic medication, 20 (31%) were identified as requiring psychiatric hospitalisation not available at the hospital, and 61 (95%) were recommended for follow-up interventions, highlighting the severity of their mental illness. 17 (27%) of the Nauruan patient group appeared to have been neglected in terms of medical care, mainly due to a lack of available mental healthcare prior to MSF’s arrival. In some cases, the lack of medical care was due to the physical health needs of patients with severe psychiatric conditions being disregarded. This indicates that access to quality healthcare was a problem in Nauru, even for the local community.

## Health environment

### The Nauruan system

Based on the observations of MSF staff, **psychiatric care was not readily available, even to Nauruan nationals, from the Republic of Nauru hospital**, as many patients did not receive psychiatric medication regularly. Based on MSF's health promotion assessment,<sup>17</sup> there was a general lack of understanding about psychiatric illnesses among the Nauruan population. From a policy perspective, local law and practice appeared inadequate to ensure that those with psychiatric illnesses received appropriate care.

The *Nauru Mentally Disordered Persons 1963* allows Nauruans to be provided with involuntary mental healthcare in a designated mental health facility or hospital. However, the Republic of Nauru hospital had no psychiatric beds to allow such treatment, and there was no way for patients to be placed on community treatment orders to receive treatment involuntarily unless they had first been admitted to hospital. The effect was that Nauruan patients who had mental disorders and who needed protection for their own or others' safety, and who were unable or unwilling to consent to treatment, could not receive mental health treatment under the current *Nauru Mentally Disordered Persons Act 1963*.

For most of MSF's project period, there was no psychiatrist affiliated with the Republic of Nauru hospital to properly assess and treat Nauruan nationals. Only in MSF's last month was a psychiatrist added (via a Cuban government support programme); however, as she spoke neither English nor Nauruan, she had no means of communicating with either patients or hospital staff. Additionally, for the majority of the project period, the nurses and the doctor responsible for mental health were not allocated sufficient time at the hospital's mental health clinic. As a result, MSF could carry out only limited capacity building with the hospital's mental health team.

Among Nauruan nationals, patients with psychiatric illness were observed to have poor family and social support. Many patients, including children, appeared to have experienced neglect and physical abuse. Amongst the Nauruan community, MSF staff also observed that alcohol abuse was common, and that children were sometimes neglected as a result of their caregivers' addiction to gambling. As



identified in MSF's health promotion assessment,<sup>17</sup> Nauruan respondents had a negative perception of people suffering from mental illness. People with mental health conditions were described as abnormal and unaware of their actions, feelings and environment. These perceptions led to stigmatisation of those with mental illness. Many people appeared ashamed to admit that they had family or friends with mental health problems.

### Access to services for refugees and asylum seekers

For asylum seekers and some refugees, additional mental healthcare was available from health service providers contracted by the Australian government, mainly International Health and Medical Services (IHMS). However, it was clear to MSF that the relationship between these service providers and the refugees and asylum seekers was often fraught.

Patients with mental health issues need to be able to establish trusting, consistent relationships with their mental health practitioner in order to make progress in therapy, particularly to address past traumatic experiences. Many refugee and asylum seeker patients found it challenging to develop trusting relationships with these providers, both because frequent staff rotations meant that clinical staff often changed, and because these organisations were perceived by some as complicit

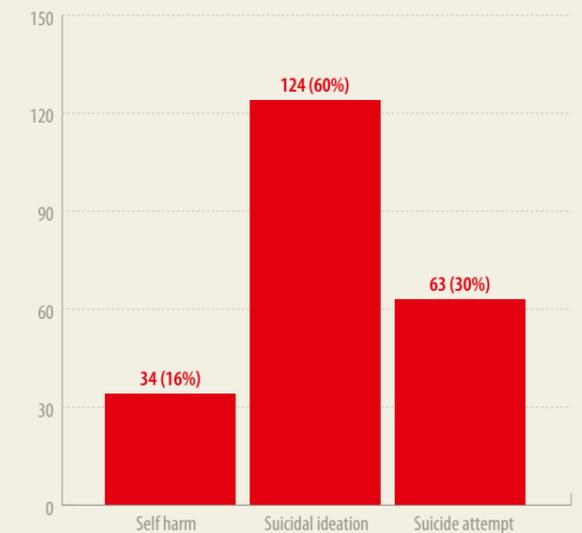
in the administration of the offshore processing policy. The challenges of service provision by IHMS have been attested to by former IHMS medical staff, whose whistleblowing accounts have been published in the media.<sup>20, 21</sup>

Even when patients accessed the mental health services supplied by the Australian government, there were significant limits to what was provided. There was one 24-hour facility with three inpatient beds in RPC1, but it was the only such facility on the island and was often full. As a result, refugee and asylum seekers who were identified as being at high risk to themselves or others, or otherwise presenting with severe symptoms of mental illness, were unable to access the level of treatment they needed.

The lack of trust felt by patients was illustrated by the number of patients who told MSF they had received inadequate care from the Australian government's mental healthcare providers. In total, MSF heard 36 allegations, 11 of them involving children, which ranged from not receiving timely and appropriate treatment to being denied treatment altogether. There was clearly a perception amongst refugees and asylum seekers that the mental healthcare provided by the Australian government was failing them.

## 4.5 Self-harm and suicidal behaviour among refugee and asylum seeker patients

Chart 15: Self-harm and suicidal behaviour among refugee and asylum seeker patients



In total, **135 (65%) refugee and asylum seeker patients seen by MSF had suicidal ideation and/or engaged in self-harm or suicidal acts** (see definitions page 26). Among MSF's refugee and asylum seeker patients, 124 (60%) had suicidal ideation, 63 (30%) had attempted suicide, and 34 (16%) had engaged in acts of self-harm [Chart 15]. Previous suicide attempts are considered the strongest risk factor for completed suicides. **Among our patients, children as young as nine were found to have suicidal ideation, had committed acts of self-harm or attempted suicide.**

Suicidal cases were often discussed in staff debriefings. The most common methods of attempting suicide were overdosing on medication, swallowing razor blades or household cleaners, cutting their wrists, or setting themselves on fire. Over time, the number of **suicide attempts increased among the refugees and asylum seekers on Nauru, for both MSF patients and those not seen by MSF. This is an expected and unfortunately predictable consequence of long-term, indefinite processing**, when people's sense of hopelessness increases and their mental health state worsens.

**Suicidal ideation:** Thoughts of self-harm with deliberate consideration or planning of possible techniques of causing one's own death.

**Suicide attempt:** Attempting to end one's own life, which may lead to one's death.

**Self-harm:** Engaging in intentional, direct injury to one's body, usually without suicidal intentions. Self-harm primarily serves to manage emotional distress by alleviating depressed or anxious feelings, or to block painful memories. On occasion, self-harm may also be a 'cry for help', whereby individuals injure themselves as a means of communicating their physical or emotional pain to others, including medical professionals.<sup>22</sup> While people who engage in self-harm may or may not be actively suicidal, the unintended consequences can lead to serious health risks and require attention and care by health professionals.

From November 2017 to October 2018, a total of 2,132 sessions were conducted by MSF, including 285 assessments (13%) and 1,847 follow-up sessions (87%). There was a general increase in the number of sessions conducted over time. A decrease in the number of sessions was observed in September 2018 as three MSF mental health staff completed their contracts and therefore took on no new patients in their final two to three weeks. The Pacific Island Forum also took place in September 2018, during which time the clinic reduced the number of appointments due to restrictions on movements. Of the 285 assessments conducted, 252 (88%) were recommended for follow-up by MSF staff. At the time of MSF's forced departure, MSF had 8 patients due for an initial assessment and 92 on a waiting list.

The average number of follow-up sessions per patient was 6.5, ranging from 0 to 48 sessions. In general, our patients required multiple follow-ups and long-term therapy due to the severity of their mental illnesses and psychological suffering. Of the 285 cases, 147 (52%) were self-referrals or referrals by family or friends, and 88 (31%) were referred by other organisations.

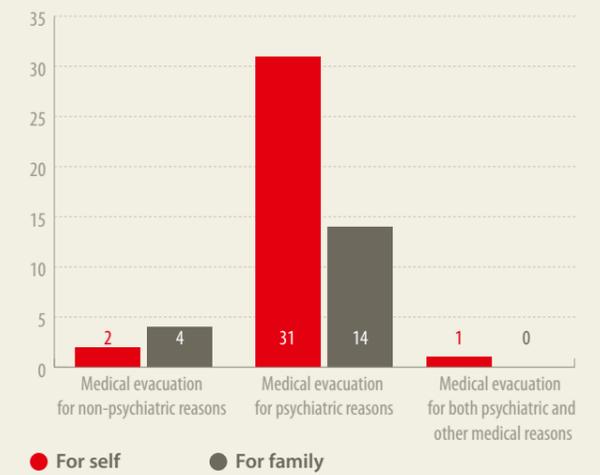
A total of 591 sessions were conducted for Nauruan patients, 1,526 sessions for refugee and asylum seeker patients, and 4 sessions for foreign workers. 11 sessions had no information on the patient's legal status.

At the start of the project, more sessions were conducted for Nauruan patients than for refugee and asylum seeker patients. This began to shift in February 2018, and from April 2018 onwards MSF conducted more sessions for refugee and asylum seeker patients than for Nauruan patients, though both Nauruan and refugee and asylum seeker patients continued to receive follow-up by MSF throughout the project [Chart 17].

The majority of Nauruan patients were diagnosed with a psychotic disorder; once their condition was stabilised on psychiatric medications, fewer follow-up sessions were required, yet MSF continued to follow these patients in collaboration with the nurses from the Republic of Nauru hospital.

Starting in May 2018, we began to see a precipitous decline in the mental health conditions of refugee and asylum seekers in Nauru, consistent with the three traumatic events reported in section 2.2, which resulted in a significant increase in self-referrals to the MSF clinic.

**Chart 18: Medical evacuation for psychiatric and other medical reasons**



**Amongst MSF patients, a total of 55 refugees and asylum seekers were medically evacuated from Nauru to Australia.** Three of these cases involved patients who had been through the triage process in our clinic but had not received an assessment due to MSF being asked to leave Nauru. Of the 52 cases assessed, 34 medical evacuations were for the patients themselves, while 18 were for the patient's family member(s). Of the 52 patients, 45 medical evacuations were for psychiatric reasons and 6 were for other medical conditions. One patient was referred for both psychiatric and other medical reasons [Chart 18]. Based on MSF data at the point of assessment, the majority of patients evacuated for psychiatric reasons had diagnoses of moderate to severe depression, suicidal ideation and anxiety disorders.

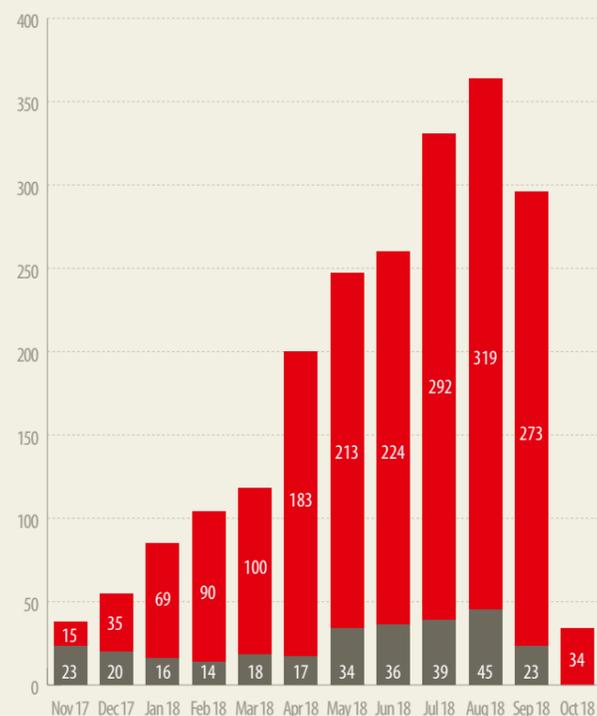
During the period in which MSF worked on Nauru, to our knowledge there were many other cases of medical evacuations that took place involving refugees who were not under MSF's care. In general, requests for medical evacuation often took a long time to process. When MSF arrived in Nauru, there were cases of children who had been referred for medical evacuation seven to eight months earlier but were still on the island.

#### 4.7 Additional data analysis on outcome measures

At the time MSF was forced to leave, MSF had 208 remaining patients. 77 other patients had already been discharged prior, 52 (18%) of whom were discharged due to a medical evacuation, while 2 others (1%) were discharged due to improved conditions and 1 (0.4%)

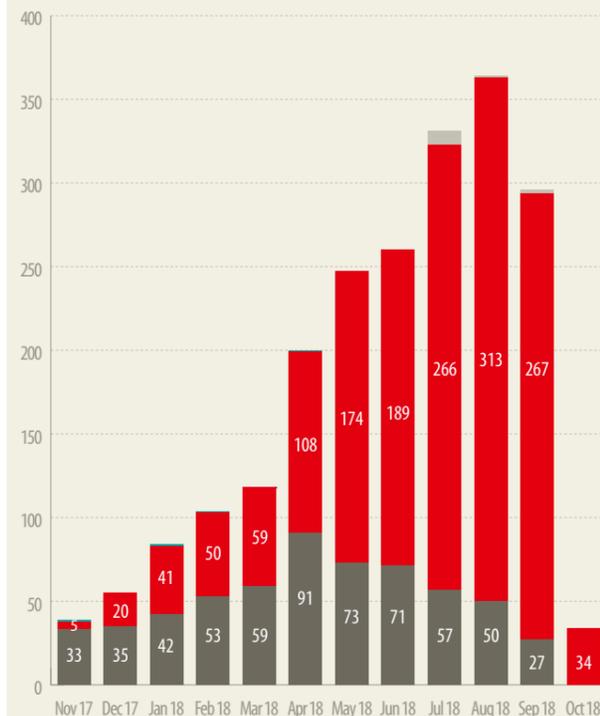
## 4.6 Service and referral

**Chart 16: No. of assessments and follow-up sessions**



● No. of assessments ● No. of follow-up sessions

**Chart 17: No. of sessions conducted for Nauruan and refugee/asylum seeker patients by month**



● Nauruan patients ● Refugee/asylum seeker patients  
● Others (Foreign worker) ● No info

“If I was in my home country, the government wants to kill me straight away. I tried to come to Australia and the government kills me a little by little, step by step. They tormented me a lot over five years on Nauru because I have no future in my life.”

**FARHAD\*, FORMER MSF PATIENT**

was discharged despite no improvements. 12 patients (4%) were lost to follow-up, 5 (2%) were referred to other organisations, and 1 (0.4%) was resettled. There was no information on the discharge status of 4 patients (1%).

When MSF departed, of our remaining 208 patients under care, as many as 60% of the Nauruans and 54% of the refugees and asylum seekers were on psychotropic medication. Our patients’ median GAF score was 41 (IQR 25-51), suggesting a population still in dire need of specialised mental health support.

Outcome analyses also explored differences of the treatment outcomes between Nauruans and refugees and asylum seekers. Comparing the GAF scores of the 112 patients seen for multiple sessions by a psychiatrist, an important distinction emerged. For 38 Nauruan patients followed over time, 7 (18%) were stable with no major change in functioning, 10 (26%) deteriorated, and 21 (55%) showed improvement. For the 74 refugees and asylum seekers seen over time, 15 (20%) remained stable, while 51 (69%) deteriorated and only 8 (11%)

showed improvement in their daily functioning. This highlights that, despite receiving equivocal treatment, asylum seekers and refugees showed less ability to recover from their mental health distress.

For more in-depth analysis, three outcome indicators were selected: the (theoretical) need for psychiatric hospitalisation, regardless of whether hospitalisation was provided; diagnosis of suicidal ideation and/or suicide attempts; and the mental health severity as characterised by a patient’s GAF score. These were related to various socio-demographic characteristics and exposure to difficulties and traumatic events as documented in the MSF mental health database. Additionally, the outcomes of the entire mental health programme, measured on 5 October 2018, were assessed.

This analysis focuses on the refugees and asylum seekers treated by MSF, so the results in *Table 4* only include the refugee and asylum seeker patient group, unless explicitly stated. The table indicates additional characteristics and possible mental health stressors among the refugee and asylum seeker population.

**Table 4: Characteristics and putative mental health stressors among refugee and asylum seeker patients**

Characteristics		N (%)
Sex	Female	107 (51)
	Male	101 (49)
Age	<18	39 (19)
	18-29	43 (21)
	30-39	61 (29)
	40-49	36 (17)
	50-59	12 (6)
	60+	2 (1)
	Not recorded	15 (7)
Time since departure from country of origin	3-5 years	95 (46)
	>5 years	73 (35)
	Not recorded	40 (19)
Presence of partner	No partner	60 (38)
	Present on Nauru	82 (51)
	Not present on Nauru	18 (11)
Presence of children	No children	78 (49)
	Present on Nauru	68 (43)
	Not present on Nauru	13 (8)
Prior detention	Any (excluding Christmas Island)	15 (7)
	On Christmas Island	145 (70)
Exposure on Nauru	Any form of physical violence	47 (23)
	Any form of sexual violence	9 (4)
	Family separation	28 (13)
	Witnessing violence	7 (3)
	Feeling at risk	6 (3)
	Lacking activities/boredom	73 (35)
	Fearing the future	134 (64)
	Feeling a lack of control	134 (64)
<b>Total</b>		<b>208</b>

In terms of outcome measures, the need for psychiatric hospitalisation and the presence of suicidality (suicidal ideation and/or suicide attempts) were alarmingly high. There was an overall need for psychiatric hospitalisation at any time among 34% of all patients (44% for the Nauruan population, 32% for refugees and asylum seekers). There was a presence of suicidal ideation and/or suicide attempts at any time among 49% of all patients (8% for the Nauruan population, 63% for refugees and asylum seekers). Among refugees and asylum seekers, associations between the need for psychiatric hospitalisation and suicidal ideation and/or attempts and the various characteristics and mental stressors are shown in Charts 19 and 20.

For the need for psychiatric hospitalisation, a significant association was found between exposure to physical violence on Nauru and requiring psychiatric hospitalisation (RR 1.7, 95%CI 1.1-2.5,

$p=0.03$ ), indicating that lack of protection on Nauru from physical violence carries a 70% higher risk of being in need of psychiatric hospitalisation (which may in many cases remain unmet).

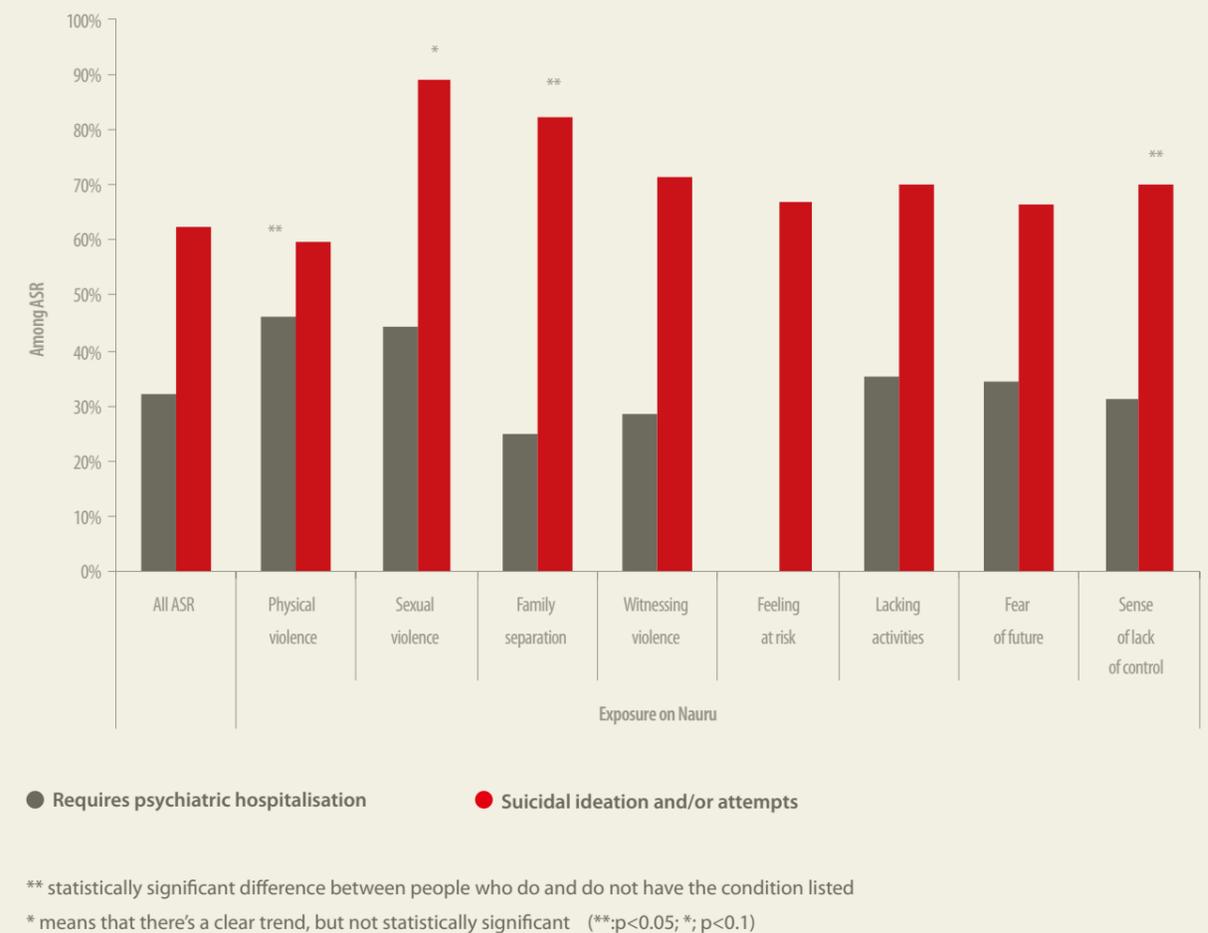
In terms of suicidal ideation and/or attempts, an association was identified with being exposed to family separation specifically due to family members being sent to Australia via medical evacuation (RR 1.4, 95%CI 1.1-1.7,  $p=0.02$ ); lacking a sense of control over events that affect one's life (RR 1.4, 95%CI 1.1-1.9,  $p=0.002$ ); and having been previously detained on Christmas Island (RR 1.5, 95%CI 1.1-2.0,  $p=0.001$ ). Additionally, a borderline significant association was found between suicidal ideation and/or attempts and not having one's partner present on Nauru, and experiencing sexual violence on Nauru. The damaging mental health effects of family separation and indefinite containment are well-documented and should have been entirely predictable to decision makers.<sup>23-25</sup>

**Chart 19: Association between the need for psychiatric hospitalisation, suicidal ideation and/or attempts and characteristics among refugee and asylum seeker patients**



\*\* statistically significant difference between people who do and do not have the condition listed  
 \* means that there's a clear trend, but not statistically significant (\*\*:p<0.05; \*:p<0.1)

**Chart 20: Associations between the need for psychiatric hospitalisation, suicidal ideation and/or attempts and mental health stressors among refugee and asylum seeker patients**

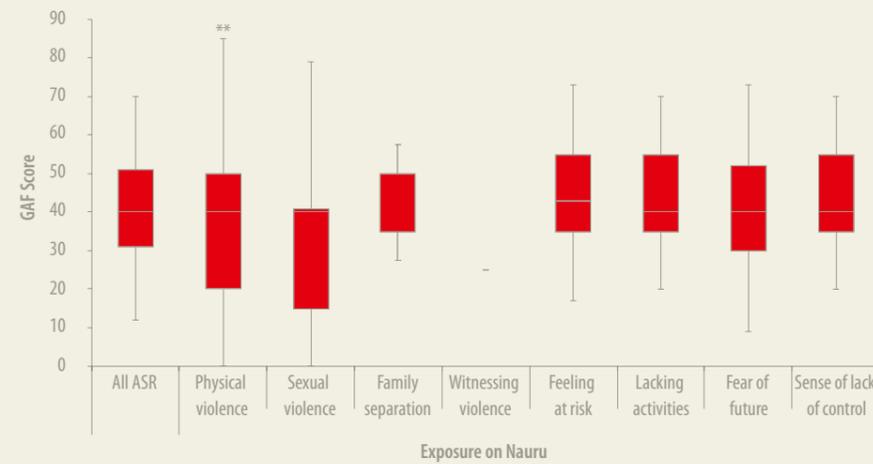


\*\* statistically significant difference between people who do and do not have the condition listed  
 \* means that there's a clear trend, but not statistically significant (\*\*:p<0.05; \*:p<0.1)

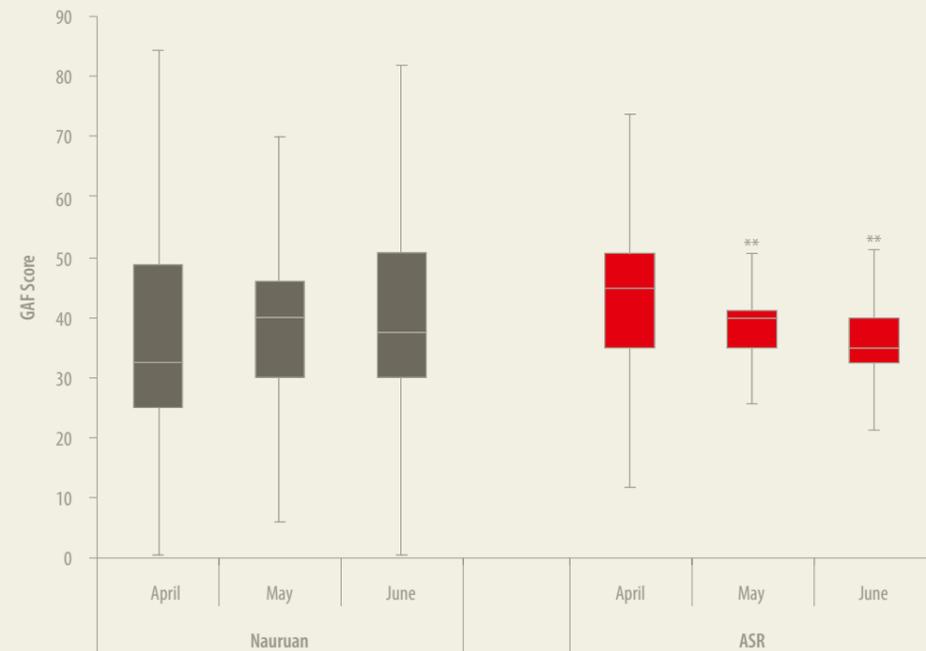
The median GAF score across the population of mental health patients at the point of assessment was 40 (IQR 29-55), reflecting the overall severity of the mental health conditions encountered on Nauru (other MSF projects that use the GAF score report medians in the range of 60, including in MSF projects providing care for victims of torture). For the Nauruan patients, the median GAF score at point of assessment was 35 (IQR 25-55), while for the refugees and asylum

seekers it was 40 (IQR 31-51). An overview of the median GAF scores is provided in Charts 21 and 22. Comparatively, lower scores were identified among Nauruan patients due to the high number of patients with psychosis. Significantly lower median GAF scores were observed for adults who did not have children, individuals who experienced violence while on Nauru and individuals who left their country of origin more than five years earlier.

**Chart 21: Median and midrange boxplots of patient GAF scores by mental health stressors (\*\*: p<0.05)**



**Chart 22: Median and midrange boxplots of GAF scores among Nauruan and refugee and asylum seeker patients attending the MSF mental health programme between April and June 2018 – the period of a high number of refusals in the context of the US resettlement program (\*\*: p<0.05)**



The impact of specific policy decisions on the mental health severity (as quantified by the GAF score) was also assessed. In May 2018, a large number of refugees and asylum seekers were refused resettlement in the United States. Among the patients who were in the care of MSF, GAF scores were compared in the period immediately before and immediately after the refusal (i.e. April to June 2018). Among refugee and asylum seeker patients (n=19), a significant decrease in GAF scores was observed (p=0.02), while for Nauruan patients (n=22) no such decrease was observed over the period of interest.

This analysis highlights the strong impact that major events related to the processing policy have on the general population of asylum seekers and refugees. Consistent with staff observations and patient reports, when a major negative event occurred to some in the community, the impact was felt not only by those directly affected, but by the population as a whole. Negative events further fractured the already tenuous coping abilities of the refugees and asylum seekers, increased their own hopelessness, and led to further deterioration of their mental health.

\*Names have been changed to protect anonymity.

## 5. CONCLUSIONS



The alarming level of severe mental illness amongst refugees and asylum seekers on the island of Nauru is closely linked to Australia's border protection policy. People's desperate sense of hopelessness, often leading to self-harm and thoughts of suicide, is linked to their fear that they may be kept on Nauru indefinitely, with no time limit or hope of escape.

In addition, the way in which Australia administers its resettlement policies is widely perceived by those on Nauru as opaque and unjust, adding to people's sense that they have no control over their lives, and compounding the symptoms of severe depression and anxiety experienced by so many people detained there.

The scale of trauma experienced by our patients on Nauru was extremely high, with 92% of refugee and asylum seeker patients facing significant difficulties and/or traumatic events. In particular, there is a strong association between physical violence experienced on Nauru and a need for psychiatric hospitalisation – a need which often goes unmet due to the lack of mental health facilities on the island.

The result of these factors is that Nauru is in the grip of a mental health disaster. On Nauru, our patients' GAF scores – an established method of gauging the severity of mental health conditions – were significantly worse than in MSF projects elsewhere in the world, including amongst victims of torture.

Despite the clear link that has been established between family separation and the risk of suicide, the Australian authorities continue to separate family members, although Federal Court judgements and recent media exposure have allegedly slowed its implementation. Given the alarmingly high rate of suicidal ideation and suicide attempts on Nauru – with 65% of our refugee and asylum seeker patients having either attempted or thought about killing themselves – it is deeply irresponsible to continue measures that actively increase this risk.

We observed a significant difference in the effect of mental health treatment, depending on whether patients were from the local community or were refugees and asylum seekers. Strikingly, more than half of MSF's Nauruan patients (55%), although extremely unwell, recorded improvements in their GAF scores under MSF's care. Only 11% of asylum seeker and refugee patients improved, while 69% deteriorated and 20% remained stable, despite receiving ongoing mental healthcare. This suggests that while MSF could stabilise some these patients, without a change to their living conditions and asylum situation, significant clinical progress was unlikely.

The forced departure of the MSF team from Nauru in October 2018 left a large number of patients in need of care. Of the 285 mental health patients enrolled in our programme, 208 (73%) were still in care at the time of MSF's departure. Of these patients, as many as 60% of the Nauruans and 54% of the refugees and

“The impossibility of treating people in this situation became clearer to me each day I was on Nauru. It was the situation that needed treatment and that needed to be changed, not the person. In my medical opinion, even the world’s best medications and most expert psychotherapy can, at this point, only have very limited effect while asylum seekers and refugees remain on Nauru. The only thing that will significantly improve their mental health condition is to leave the island and be brought to a safe and stable living situation.”

DR ROBYN OSROW, MSF PSYCHIATRIST

asylum seekers were on psychotropic medication. When the project closed, our patients’ median GAF score was 41 (IQR 25-51), suggesting a population still in dire need of specialised mental health support.

With regard to our Nauruan patients specifically, we were pleased with the improvements in their functioning under our care. We appeal to the government of Nauru to invest in building sufficient resources to meet the vital needs of their own population. At minimum, the hospital should add an inpatient psychiatric unit to allow for stabilisation of patients when they are in acute mental health crises. They should ensure they have a sufficient number of mental health staff who are properly trained to work with child and adult patients with a range of mental illnesses and are able to easily communicate with patients. The public health department should be supported in providing further outreach and education about mental health to all those living on Nauru in order to reduce stigmatisation.

For refugees and asylum seekers, the situation is more dire, and yet was tragically predictable. The relationship between mental health issues and indefinite detention is well documented, and on Nauru MSF found a mental health crisis caused by our patients being held indefinitely and arbitrarily deprived of any control over their futures by an inhumane policy which leave them in indefinite despair.

Hope for a resolution for the current, or any future, population of refugees and asylum seekers remaining

on Nauru is remote. The environment for the delivery of effective mental health on Nauru was already challenging when MSF arrived but became progressively more difficult. This was partially due to the antagonistic attitude of key stakeholders towards those exhibiting mental health problems and repeated refusal to collaborate with MSF in the best interest of patients. The forced departure of MSF without adequate provision for handover of vulnerable patients was consistent with this hostile attitude and a lack of appropriate concern for seriously ill patients. These events consistently highlighted how the maintenance of the policy takes precedence over the well-being of asylum seekers and refugees held on Nauru, leading to compromise on medical care and ethics.

MSF therefore reiterates the call to immediately evacuate all refugees and asylum seekers from Nauru to a place where they can rebuild their mental health and to end the policy of indefinite offshore processing. This policy predictably destroys the will to live of innocent human beings. Therefore, it is the opinion of MSF that the safest way to prevent further harm, is to allow all refugees and asylum seekers to be evacuated from Nauru independently of their current mental health condition. Recovery is possible, but it requires an environment of certainty and opportunity, with access to quality, comprehensive mental health care. Anything short of that will continue the suffering that is being imposed on asylum seekers and refugees on Nauru.

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## 7. APPENDIX

### Global Assessment of Functioning (GAF) Scale (From DSM-IV-TR, p. 34.)

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code	(Note: Use intermediate codes when appropriate, e.g. 45, 68, 72.)
100–91:	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
90–81	Absent or minimal symptoms (e.g. mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities. Socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g. an occasional argument with family members).
80–71	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g. difficulty concentrating after family argument); no more than slight impairment in social, occupational or school functioning (e.g. temporarily failing behind in schoolwork).
70–61	Some mild symptoms (e.g. depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g. occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
60–51:	Moderate symptoms (e.g. flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g. few friends, conflicts with peers or co-workers).
50–41	Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g. no friends, unable to keep a job).
40–31	Some impairment in reality testing or communication (e.g. speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g. depressed adult avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
30–21	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g. sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g. stays in bed all day; no job, home, or friends).
20–11	Some danger of hurting self or others (e.g. suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g. smears feces) OR gross impairment in communication (e.g. largely incoherent or mute).
10–1	Persistent danger of severely hurting self or others (e.g. recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
0	Inadequate information.

