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Submission to the

Inquiry into Immigration Detention in Australia

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Executive Summary

A thorough review of relevant psychological theory and available research findings from international research has led the Australian Psychological Society to conclude that:

- Detention is a negative socialisation experience.
- Detention exacerbates the impacts of other traumas.

The first and foremost need that should be recognised is to assist refugees to "develop a sense of stability, safety and trust, as well as to regain a sense of control over their lives" (Ehntholt & Yule, 2006, p. 1202). The experience of immigration detention has been shown to be counter to addressing these needs. We acknowledge the good work of the Department of Immigration over the past year in developing good practice standards of health care for people in detention, but believe that people are better serviced by regular health services.

Therefore the APS strongly advocates for community options to be made available to allow for the best utilisation of health services to be provided.

We acknowledge that many positive changes have occurred in immigration detention over the past two years, since the Palmer and Comrie reports. These improvements, however, do not take away from the research findings and our conclusions that detention is detrimental to people's wellbeing.

We believe that further improvements are possible to reduce the risks of adverse mental health outcomes for refugees and asylum seekers. These include:

- Immigration detention should be only short term for as long as is needed to enable appropriate security and health clearances to be completed; with adequate resourcing this should take no longer than two weeks in the majority of cases;
- After two weeks in detention, cases should be reviewed, preferably by, or in conjunction with, an independent authority. The Department would need to justify why more time in detention is necessary;
- Options for community based alternatives to immigration detention should be developed to better facilitate the mental health of asylum seekers and enable providers to support positive psychological health interventions;
- Opportunities for independent income and the normalisation of family structures, parental roles and responsibilities and daily activities such as work and education should be maximised;
- Families with children should not be kept in detention, but placed in the community;
- Family groups should be maintained;
- Immigration detainees should be allowed to reside in the community where health care needs can be better met;
- Screening and the provision of mental health care should be demonstrably independent of the custodial organization;

- Persons identified as suffering from mental illness should be removed immediately from detention and treated within the community;
- Mental health care provided to persons in immigration detention should be provided by culturally competent mainstream mental health services;
- The special mental health needs of refugees and asylum-seekers, if they must be detained for any period, are more likely to be met adequately by the provision of mental health care through existing state mental health services, which will need additional support for this task.

It is unclear how any of the above recommendations could be implemented in the context of off-shore detention or detention on excised territories.

1. Introduction

The APS welcomes the opportunity to provide input to the Inquiry into Immigration Detention in Australia insofar as it impacts on the mental health, wellbeing and human rights of refugees and asylum seekers. The profession of psychology is well placed to contribute to the current inquiry through its evidence-based and integrated approach to such issues.

About the Australian Psychological Society

The APS is the premier professional association for psychologists in Australia, representing over 16,500 members. Psychology is a discipline that systematically addresses the many facets of human experience and functioning at individual, family and societal levels. Psychology covers many highly specialised areas, but all psychologists share foundational training in human development and the constructs of healthy functioning. Psychologists frequently work in a multidisciplinary context with other health professionals, including GPs, to support wellbeing, to contribute to the effective management of emotional health life event-related problems, and to address mental health concerns.

The APS supports nine professional Colleges that promote specialist areas of psychology, including the Colleges of Clinical, Clinical Neuropsychology, Community, Counselling, Educational & Developmental, Forensic, Health and Organisational Psychologists. A range of interest groups within the APS also reflect the Society's commitment to investigating the problems, of and promoting equity for, refugees and asylum seekers, Indigenous Australians, women, gay and lesbian people, children, adolescents and families.

Organisation of APS submission

The APS submission will confine itself to comments regarding the mental health and wellbeing concerns of immigration detainees, particularly refugees and asylum seekers, in the following sections:

- Duration of detention;
- Criteria for determining when a person should be released from immigration detention;
- Options for the provision of detention services and detention health services across the range of current detention facilities;
- Alternatives to detention.

In compiling this submission, we have drawn extensively on a recently completed Literature Review titled *Psychological Wellbeing of Refugees Resettling in Australia* commissioned by the APS in the public interest (Murray, Davidson, & Schweitzer, 2008). The complete paper can be accessed from the APS web site: http://www.psychology.org.au/community/public_interest/#s7

The Australian Psychological Society is opposed to mandatory detention because of its deleterious effects on the mental health of detainees, and applauds the recently announced changes to government policy. The APS supports models of community detention which have been successful overseas. This submission outlines the research on the impacts of mandatory detention on mental health, issues to consider in the delivery of health services to asylum seekers and finally a brief summation of preferred community-based options.

Duration of detention

Immigration detention is inherently undesirable and should be resorted to only in exceptional circumstances, according to UNHCR detention guidelines. Prolonged or indefinite detention has clearly documented deleterious effects on the mental health and wellbeing of detainees (Steel et al., 2004), especially children (Mares et al., 2002). In one study, being previously detained or being under temporary protection contributed independently to risk of ongoing Post-Traumatic Stress Disorder (PTSD), depression and mental health-related disability (Steel et al., 2006). Longer detention was associated with more severe mental disturbance, an effect that lasted on average for 3 years following release into the community (Steel et al., 2006). This is particularly so for people already in a vulnerable state or with pre-existing mental health concerns (see review of the literature by Thomas and Lau, 2002), which is often the case for people who have suffered in fleeing persecution and seeking protection in Australia. Detention exacerbates this vulnerable state.

Studies have shown that high rates of psychopathology are significantly exacerbated during stays in processing centres awaiting assessment (McKelvey & Webb, 1997). Procedures related to awaiting asylum determination have been found to contribute to elevated stress levels in children and adolescents (Sourander, 1998). The use of detention centres that are remote and isolated is particularly problematic. These remote centres accelerate the disintegration of inmates and exacerbate the difficulties of integrating into the community once issued with a visa.

Children are particularly vulnerable to the deleterious effects of immigration detention. A review of the literature by Thomas and Lau (2002) into the mental health of children and adolescents in the process of sought asylum, show clearly that children and adolescents living in shelters, camps and processing centres are subjected to increased risk for psychological dysfunction (Rudic, Rakic, Ispanovic-Radojkovic, Bojanin & Lazic, 1993). Studies of children in Australian's detention centres have reported extremely high levels of psychopathology, particularly following prolonged periods in detention (Mares et al., 2002; Mares & Jureidini, 2004; Steel et al., 2004; Report of the National Inquiry into Children in Immigration Detention, Human Rights & Equal Opportunity Commission, 2004).

Whilst we acknowledge the improvements in immigration detention over the past two years, both attitudinal and practical, since the Palmer and Comrie reports, it is still the opinion of the APS, that mandatory detention of all asylum seekers arriving undocumented is inappropriate. We welcome the recent announcement of changes to detention arrangements in Australia to cease mandatory detention except for those who pose a risk to the community or of absconding, and for children to never be detained in a detention centre. It remains unclear how these commitments can or will be implemented in the case of detention on excised territories such as Christmas Island.

The duration of detention where it is deemed necessary should be based on assessment of risks to the community and /or of risks of absconding. There appears to be very little evidence that the latter risk is high when asylum seekers are offered open community detention. In Australia, research at Hotham Mission with 554 asylum seekers living in the community over 5 years, found that 79% of those refused refugee status voluntarily left Australia, and less than 1% absconded (Mitchell, 2007). The Swedish model of using detention only as a last resort has also been found to impact on higher levels of voluntary departure and low levels of absconding (Mitchell, 2001).

The timely assessment of health and security risks is a matter of adequate resourcing. There is no evidence that people who arrive in Australia in an unauthorised manner (e.g. without a valid visa) pose any greater security risk than those authorised arrivals who typically apply for protection and are permitted to remain in the community while their claims are being processed.

- Immigration detention should be only short term for as long as is needed to enable appropriate security and health clearances to be completed; with adequate resourcing this should take no longer than two weeks in the majority of cases.

Criteria for releasing a person from immigration detention.

The APS welcomes recent changes to immigration detention that require the Department of Immigration and Citizenship to justify a decision to detain – not presume - detention. In other words, the Department now needs to determine criteria for continuing to detain a person, rather than for releasing a person. These changes in immigration policy need to be enacted into legislation, so that immigration detention is only ever used as a measure of last resort for all people, not just children, for health, character, identity and security checks, or where there is a proven ongoing security need.

- After two weeks in detention, cases should be reviewed, preferably by, or in conjunction with, an independent authority. The Department would need to justify why more time in detention is necessary.

Alternatives to detention

Mandatory detention policies are an example of the compounding of pre-migration trauma by the 'anti-humanitarian' nature of the treatment received by some refugees in the Australian setting. A meta-analysis by Porter and Haslam (2005) combined pre- and post-displacement factors over 56 studies of refugee mental health to provide insights into the overall trends within those data. They found that, among other factors, refugees who were in institutional accommodation and had restricted economic opportunity had worse mental health outcomes. Importantly, they found that post-displacement factors moderated outcomes. Similarly, those who report a loss of meaningful social roles and loss of important life projects, are unemployed or facing economic hardship and/or report being socially isolated are all at risk of worse outcomes in resettlement. All of these factors characterise the detention experience, even (though to a lesser extent) in community detention settings.
The nature of the Australian humanitarian program may interact with various individual characteristics and circumstances to affect refugee responses in resettlement. Colic-Peisker and Tilbury (2003) suggest that active ('achievers' and 'consumers') versus passive ('endurers' and 'victims') approaches to resettlement by the refugees may interact with host community reactions to refugees. The interaction between person and environment in resettlement cannot be overlooked, insofar as such environments support or hinder the empowerment of refugees or engender a sense of helplessness, passivity and despair.

The APS recognises the importance of the family unit in enabling people to achieve the stability required to recover from trauma, cope with major change, and continue their lives. Studies of children who have been displaced from their home due to war or persecution have found that depressive symptoms were more evident in children who had experienced separation from their parents and displacement than those who remained with their parents (Macksoud & Aber, 1996). Furthermore, parental psychological well-being is known to be a key factor in the mental

health of child/adolescent refugee and asylum seekers (Papageorgiou et al., 2000; Sack et al., 1994). Minimising the stress and trauma for the parents, and keeping families together, maximises the chance for recovery of mental health and wellbeing in children and adolescents.

Other research has shown that alternative management of families seeking asylum can have positive impacts on children's adjustment. For example, Markowitz (1996) described the situation of Bosnian Muslim refugees living in Israel while awaiting placement. Although their future placement was unknown, families seeking asylum were maintained as units and the head of the family worked and provided for the family, thus avoiding dependence on authorities. In that situation, parental roles and practices were sustained and the sense of stability that prevailed while families were 'in limbo' had positive effects on children's adjustment to their changing circumstances. This model provides an exemplar for an alternative approach to the detention of asylum seekers in the Australian context.

Community based support and case management of asylum seekers has better impacts on asylum seeker mental health and has been shown to cost less than the current detention regime (Justice for Asylum Seeker Alliance, 2004).

- Opportunities for independent income and the normalisation of family structures, parental roles and responsibilities, and daily activities such as work and education should be maximised;
- Families with children should not be kept in detention, but placed in the community;
- Family groups should be maintained.

Options for the provision of detention health services across the range of current detention facilities

Research examining the mental health of refugee claimants in immigration detention has shown the deleterious effects of detention. Dudley (2003) estimates that the rates of suicidal behaviours among men and women in these Australian detention centres are approximately 41 and 26 times the national average, respectively. Furthermore, male refugee claimants in detention have rates of suicidal behaviour that are 1.8 times higher male prison rates (Dudley, 2003). Mares and Jureidini (2004) confirmed these high levels of psychological distress among adults and children in detention and noted that there was very little support and few interventions provided in those settings. A host of other factors, including a number of policy-related variables like conflict with immigration officials, obstacles to employment and delays in processing of the refugee's application, were associated with psychiatric distress (Silove, Sinnerbrink et al., 1999). The detention setting places many obstacles in the way of clinicians servicing detainees and making significant improvements in such an impoverished environment is improbable.

Indefinite and protracted immigration detention causes psychological harm in adults and children (Thomas & Lau, 2002), and high levels of mental illness will continue with people who are detained in immigration detention facilities. Immigration detention is an inappropriate place to provide mental health care. Detention facilities have a focus on security rather than care and the routine practices and resultant atmosphere are not only not unsupportive but actively antagonistic to the maintenance or recovery of mental health.

Over the last 25 years, a global interest in the mental health of refugees has generated a significant body of research which permits some conclusions regarding good psychological

practice with refugees in resettlement countries. Refugees frequently struggle to overcome the psychological impacts of personal safety threats and of social, cultural dislocation. Furthermore, they face additional social, linguistic, educational and vocational challenges throughout their attempts to obtain asylum and following resettlement. In order for psychology to assist refugees to respond effectively to these traumas and stresses, psychologists require therapeutic interventions that respond holistically to the unique experiences of individuals and families. The first and foremost need that should be recognised is to assist refugees to "develop a sense of stability, safety and trust, as well as to regain a sense of control over their lives" (Ehntholt & Yule, 2006, p. 1202). The experience of immigration detention has been shown to be counter to addressing these needs. Therefore the APS strongly advocates for community options to be made available to allow for the best utilisation of health services to be provided.

Mental health practitioners working within detention centres are at risk of being ethically and professionally compromised in their duty of care, and there is the need to consider the ethical dilemmas that these services raise for professionals. They are being required to work in an environment that is non-conducive to effective treatment being implemented and that is, in fact, inherently bad for mental health. There is often a lack of clarity about who has duty of care, mental health care providers cannot ensure that their clinical opinions are being followed, continuity of care is usually absent or impossible, and they are not seen by the detainees as working independently of the interests of management.

Century et al. (2007) interviewed mental health counsellors working with refugee clients in Britain. Counsellors reported feeling "conflicted, troubled and out of their depth by experiences" in addition to having to face a range of ethical challenges (p.23). The ethical challenges include the blurring of provider-client boundaries when individuals have different expectations of provider and client roles (Savin & Martinez, 2006).

The Australian Psychological Society Code of Ethics (2007) states that:

Psychologists demonstrate their respect for people by acknowledging their legal rights and moral rights, their dignity and right to participate in decisions affecting their lives. ... Psychologists acknowledge people's right to be treated fairly without discrimination or favouritism, and they endeavour to ensure that all people have reasonable and fair access to psychological services and share in the benefits that the practice of psychology can offer.

Psychologists assist their clients to address unfair discrimination or prejudice that is directed against the clients.

The Code thus carries an expectation that psychologists may advocate on behalf of clients in order to bring to an end unjust or inhumane treatment (Kisely, Stevens, Hart, & Douglas, 2002; McNeill, 2003; Silove, 2002). That may mean psychologists not working in conditions that adversely affect refugee mental health and finding alternative options, separating the roles of detention contractors from health care contractors who provide staff and services in immigration detention facilities (Fazel & Silove, 2006) etc. It also means working to ensure equitable access and to remove barriers to quality care, as well as the development of new models of service delivery to match services to the needs of individuals and communities in various settings (Kelaher & Manderson, 2000).

Where the provision of detention services is contracted to agencies that operate in prison settings, such service provision is likely to replicate the conditions of a corrections environment. This approach may be suitable for a small proportion of the current detention centre population, but should not be the way in which most clients are managed. Contracts with providers should

reflect this position. Certain past practices of managing mental health problems within detention centres are unacceptable and increase trauma (for example the use of 'Management Units' and solitary confinement, hand-cuffing and excessive physical force, using psychotropic medications for behavioural control).

The APS fully supports the review of current SASH (suicide and self harm) protocols which are in place in immigration detention centres. Together with the Detention Health Advisory Group on which the APS is represented, we acknowledge that the Department is developing evidence-based policies and procedures in regard to Suicide and Self harm issues.

Questions to consider in the context of providing services to people in detention include:

- What steps are taken to monitor the psychological welfare of refugees and asylum seekers? In particular, what steps are taken to monitor the psychological wellbeing of people arriving from war-torn countries?
- What are the qualifications and training of staff who care for detainees? What knowledge do they have of psychological issues faced by people who have been subjected to traumatic experiences and are suffering high degrees of anxiety, stress and uncertainty?
- What opportunities are in place for the assessment of safety issues such as bullying, and sexual or physical abuse of people in detention centres?
- What provisions are in place to ensure the maintenance of privacy in a manner commensurate with usual cultural practice?
- What provisions have been made for families who have been seriously affected by the asylum experience to participate in family therapy?
- Where families are placed in community detention, what provisions are in place for parenting programs that provide support for parents under extremely difficult psychological and physical circumstances?
- What efforts are being made to provide parents with the opportunity to model traditional family roles for children, such as working to earn an income, meal preparation, other household duties, etc.?
- What socialisation opportunities are available in community detention contexts for children to develop skills and independence, engage in social activities, participate in cultural traditions, and communicate and interact with same-age peers and adults from similar ethnic and religious backgrounds?

There are also concerns about the separation of mental health care of detainees from the mainstream mental health system. The APS acknowledges the good work that the Department has done over the past year in developing good practice standards of health care for people in detention, but believe that people are better serviced by regular health services. The mental health care of detainees needs to be subject to the same standards of care applied to mental health services in this country. Mechanisms of accountability and legislation and policies to protect patients' rights need to be applied in detention centres. State mental health services will require extra funding and resources in order to be able to adequately provide necessary mental health care to detainees, in addition to their existing workloads, particularly since some refugees are seriously traumatised. It is also important to be aware that traumatised persons may present poorly, especially for assessment purposes. This is likely to be exacerbated by language difficulties and culturally inappropriate treatment. Only an empowering, relatively safe and 'normal' environment can provide an effective context for assessment and support.

The APS recommends that:

- Immigration detainees be allowed to reside in the community where health care needs can be better met;
- Screening and the provision of mental health care be demonstrably independent of the custodial organisation;
- Persons identified as suffering from mental illness be removed immediately from detention and treated within the community;
- Mental health care provided to persons in immigration detention be provided by culturally competent mainstream mental health services;
- The special mental health needs of refugees and asylum-seekers, if they must be detained for any period, are more likely to be met adequately by the provision of mental health care through existing state mental health services, which will need additional support for this task

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