THE ROYAL
AUSTRALIAN AND NEW ZEALAND
COLLEGE OF PSYCHIATRISTS

29 July 2005

Senator Crossin
Chair, Senate Legal and Constitutional Committee
Department of the Senate
Parliament House
Canberra ACT 2600
Australia

Dear Senator Crossin,

Enclosed is the Royal Australian and New Zealand College of Psychiatrists (RANZCP) submission to the Senate Legal and Constitutional Committee Inquiry into the Administration and Operation of the Migration Act, 1958. The RANZCP welcomes the opportunity to contribute to this important inquiry and would be pleased to provide any additional information the Committee may require.

Yours sincerely,

Julian Freidin

Dr Julian Freidin
President

Cn:00559

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

Submission to the Senate Legal and Constitutional References Committee's Inquiry into the Administration and Operation of the Migration Act 1958

PURPOSE

This submission is made by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to address the Senate Legal and Constitutional References Committee's Inquiry into the Administration and Operation of the Migration Act 1958.

INTRODUCTION

The RANZCP is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand. It has responsibility for setting the training program, examining and providing access to Fellowship of the College to medical practitioners. There are currently approximately 2600 Fellows of the RANZCP who account for approximately 85% of all practicing psychiatrists in Australia and over 50% of psychiatrists in New Zealand. There are branches of the RANZCP in each State of Australia, and the ACT and New Zealand.

Psychiatrists are medical practitioners with a recognised specialist qualification in psychiatry. By virtue of their specialist training they bring a comprehensive and integrated biopsychosocial and cultural approach to the diagnosis, assessment, treatment and prevention of mental health problems. Thus, psychiatrists are well equipped to assess the mental health needs of those in immigration detention and the effects of immigration detention on mental health. This submission by the RANZCP focuses on the inquiry's Terms of Reference:

> *(c) the adequacy of healthcare, including mental healthcare, and other services and assistance provided to people in immigration detention*; and
>
> *(d) the outsourcing of management and service provision at immigration detention centres*.

MENTAL HEALTH AND IMMIGRATION DETENTION

Immigration is associated with high levels of mental illness

Rates of mental illness – post-traumatic stress disorder, depression, anxiety – are very high among people in immigration detention. Detention contributes to feelings of anxiety, hopelessness and depression. Sultan and O'Sullivan (2001) report a pattern of psychological reactions among those held in detention for long periods. After an initial period of shock, detainees typically exhibit symptoms of major depressive disorder which worsen over time, and may eventually develop psychotic symptoms such as delusions and hallucinations. These authors surveyed 33 detainees at the Villawood Detention Centre in Sydney, who had been in detention for more than nine months. All but one of these people displayed symptoms of psychological distress at some stage of their detention. 85% had chronic depressive symptoms and around half of the respondents had very severe depression. Seven respondents showed signs of psychosis, including persecutory delusions, ideas of reference, and auditory hallucinations. 65% of respondents had pronounced suicidal ideation. A survey of Tamil asylum seekers found significantly higher levels of mental illness – depression, post-traumatic stress disorder, anxiety, panic and physical symptoms – in those detained at the Maribynong Detention Centre compared with those living in the community (Thompson et al., 1998). In another study describing the psychiatric status of families in an unnamed Australian detention centre (average length of time in detention two years and four months; Steel et al., 2004), all the adult detainees were diagnosed with a major depressive disorder, and a majority with post-traumatic stress disorder. Two adults showed psychotic symptoms, and met criteria for a severe major depressive disorder with psychotic features. Almost all the adults assessed had experienced persistent thoughts of suicide, though none had had suicidal thoughts prior to detention; a third of the adults had harmed themselves.

Many detainees – in particular, those seeking asylum in Australia have suffered human rights abuses, including torture, in their countries of origin; family members may have disappeared or been murdered, and many are separated from their loved ones as well as their homes and countries. The traumatic histories of this group makes them particularly vulnerable to the effects of further psychological distress. Overall, prolonged detention exacerbates existing psychological distress and precipitates further mental illness.

Children are particularly vulnerable to the effects of prolonged detention. Parenting capacity and child protection are significantly compromised in the detention environment and rates of depression and post-traumatic stress disorder (PTSD) are high. Children are adversely affected by institutionalisation, witnessing adult distress, parental depression and emotional withdrawal, limited educational and recreational opportunities and isolation (Mares et al., 2002). Children not uncommonly self-harm, a pattern that is not noted in the general community. Studies of children in prolonged detention (more than two years) found that all children were diagnosed with at least one psychiatric disorder and 80% were diagnosed with multiple disorders. There was a 10-fold increase in total number of diagnoses found during the period of detention

compared to pre-existing rates (Mares and Jureidini, 2004; Steel et al., 2004). The holding of children in detention centres raises issues of child protection, as children are also at risk of harm due to their enforced proximity to potentially dangerous adults.

Detention centres are unable to treat mental illness

The current provision of mental health services to people in detention is clearly inadequate. Existing systems do not understand, recognise or respond adequately or appropriately to mental disorder. The recent case of the prolonged detention of Cornelia Rau clearly illustrates this. This constitutes a failure of duty of care for detainees who are mentally ill, as emphasised recently in a judgement in the Federal Court of Australia (S v Secretary, Department of Immigration & Multicultural & Indigenous Affairs (2005) FCA 549). Justice Finn said "Given the known mental conditions of the applicants, the Commonwealth permitted its contractor to provide an inadequate and, on the evidence, poorly functioning mental health care service to them." The Commonwealth, he said, was "guilty of neglect of its duty."

Detention centres are an unsuitable location for treatment. Psychiatric illness requires an appropriate treatment environment, trained nursing and mental health staff, and a comprehensive biopsychosocial treatment approach. The immigration detention centre does not have adequate mental health staff, appropriately-trained supervisory staff, or adequate capacity to review and monitor biological treatments. The use of inappropriate behavioural management techniques, including solitary confinement is of great concern to the RANZCP. These techniques are not considered to be standard treatment of behavioural disturbance resulting from mental illness, and are not acceptable to international psychiatric bodies. Brief uses of low stimulus environments are only used as part of overall comprehensive treatment of mental illness. The use of antipsychotic medications for behavioural control is inappropriate. We are also concerned that the environment of the detention centre creates a culture which perceives disturbed behaviour as deliberately disruptive, rather than a symptom of illness.

The RANZCP believes that the subcontracting of detention, which produces a separation of the mental healthcare of detainees from the mainstream mental health system, is a key factor in the deficient treatment of mental illness in detention centres. At present, there is no formalised arrangement between the detention centres and state mental health services. It can be very difficult to find appropriate treatment for mentally ill detainees, particularly in area mental health services already stretched to capacity.

Healthcare providers should work separately from detention providers

Psychiatrists employed by detention providers are placed in a position which amounts to a conflict of interest. Their professional duty of care to their patients is compromised in an environment which is of itself harmful to mental health, which does not meet national or international standards for healthcare, and where their recommendations are not taken up. Furthermore, the employment of psychiatrists by

detention providers may compromise the trust necessary to build a therapeutic rapport between psychiatrist and patient. Sultan and O' Sullivan (2001) observed that "Access to medical services sometimes has to be negotiated through correctional centre staff, especially after hours or during security incidents. Detainees may then perceive medical practitioners as being aligned with the detaining authorities and are concerned that this may hinder them in acting in their best interests".

RECOMMENDATIONS

Prolonged, indefinite immigration detention causes psychological harm in an already vulnerable population. High levels of mental illness will continue to occur as long as immigration policy is implemented in this way. The RANZCP recommends that prolonged detention is replaced by an alternative system, such as community placements, with detention centres used only for brief initial processing.

If the mandatory detention model is maintained, then standards of care applying to mental health services generally must also apply for mental health services in immigration detention. Systems must be set in place to ensure that detainees suffering psychiatric symptoms are adequately assessed and treated for the inevitable mental health problems that will arise. At a minimum, independent review panels of clinicians must be established to assess detainees for mental illness, and assessments must be conducted regularly. Responsibility for such panels should be assigned to state mental health services to ensure their independence. If a person is found to be mentally ill, he or she must be removed from detention to an appropriate place of treatment.

Mental healthcare to detainees should be provided by mainstream mental health services, independent of the immigration department or detention provider. Alternatives to the already overstretched public mental services will need to be made available. This could include better utilisation of the private health system. Care must be taken to avoid significant disruption to public health services or the re-creation, by the use of harsh security measures, a detention environment in a hospital setting.

Any establishment of additional services to support detainees who have become unwell as a consequence of their detention and the detention environment will need to be funded with additional resources to ensure that the capacity of existing mental health services is not further compromised.

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